DOCUMENT RESUME

ED 460 324 CG 031 416

AUTHOR	Kirmayer, Laurence J.; Boothroyd, Lucy J.; Laliberte, Arlene; Simpson, Brenda Laronde
TITLE	Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities. Culture and Mental Health Research Unit Report.
REPORT NO	R-9
PUB DATE	1999-00-00
NOTE	90p.; Supported by a grant from the Conseil Quebecois de la Recherche Sociale (Native Mental Health Team). Available in English and French online.
AVAILABLE FROM	Culture and Mental Health Research Unit, Institute of Community and Family Psychiatry, Sir Mortimer B. Davis--Jewish General Hospital, 4333 Cheminde la Cote Ste-Catherine, Montreal Quebec H3T 1E4 ($20). Tel: 514-340-8222, ext. 5246; Fax: 514-340-7503; e-mail: mice@musica.mcgill.ca. For full text: http://ww2.mcgill.ca/psychiatry/transcultural/pdf/Report9_Eng.pdf.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Adolescents; At Risk Persons; *Canada Natives; *Community Health Services; Community Programs; *Eskimos; Foreign Countries; Integrated Services; *Prevention; Program Development; Program Effectiveness; Resilience (Personality); Secondary School Students; *Suicide
IDENTIFIERS	*Adolescent Suicide; Eskimo Culture; First Nations; Suicide Ideation

ABSTRACT

The high rates of suicide, attempted suicide, and suicidal ideation among youth in many Native communities indicate that the problem is not just with individuals but involves community-wide issues. Thus, a community-based approach to prevention is essential. This report sets out a rationale and guidelines for a community-based prevention program for First Nations and Inuit youth. The levels and types of prevention are briefly outlined. Major risk and protective factors for suicide that inform prevention programs are reviewed. Elements of suicide prevention programs that have been shown to be effective are discussed. The final two sections present program guidelines and recommendations. The recommendations are based on a systematic review of prevention and mental health promotion programs, including school-based programs, developed for or potentially applicable to Native populations. Recommended programs are described in Appendix A and brief descriptions and contact information for all the reviewed programs are included in Appendix B. Appendix C lists the resources used to review the programs. (Contains 1 table, 1 figure, and 99 references.) (JDM)

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Culture & Mental Health Research Unit
Report No. 9

Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities

Institute of Community & Family Psychiatry
Sir Mortimer B. Davis—Jewish General Hospital

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Culture & Mental Health Research Unit
Report No. 9

NATIVE MENTAL HEALTH RESEARCH TEAM

Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities

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Preamble

The information in this report was compiled in 1998 and the spring of 1999. We are interested in updating this document. If you have additions, corrections, or new programs to suggest please contact us at the address on the previous page.

This report has been translated into French as "Prévention du suicide et promotion de la santé mentale chez les premières nations et communautés inuits." Copies of the document in English or French are available from the Culture & Mental Health Research Unit or on the Internet at **www.mcgill.ca/psychiatry/transcultural/cmhru.html**.

Errata

The last paragraph on page 51 should read:
Please note that all of the programs presented in Appendix B are described in English; French descriptions of the Quebec school-based programs can be found in the French version of this report.

The reproduction of Table B1 (page 52) is light, which may result in difficulty identifying the shaded areas. For clarification:

- the focus for program #1 is specifically suicide (target groups: adolescents, adults, caregivers/school staff);
- the focus of programs #2 and 3 is general mental health (target groups for both programs: children, adults, women/girls).

Preface

In this report, we set out a rationale and plan of action for suicide prevention and mental health promotion in the First Nations and Inuit communities of Québec. The recommendations are based on the best available information and evaluations of existing programs. We hope this will be a useful resource for communities and individuals developing and implementing programs to meet their local needs.

This report draws from earlier reviews prepared by our group for the Royal Commission on Aboriginal Peoples. In response to requests for program materials on suicide prevention from the public health department of Nunavik and social services of the Atikamekw Nation, we have attempted to review the available literature and distill practical guidelines that take into account the specific needs and constraints of remote rural Native communities in Québec and across Canada.

Acknowledgment

We have benefited greatly from meetings with representatives of the Nunavik Regional Board of Health and Social Services, the Department of Public Health and other community representatives. The review of community and clinical suicide prevention programs was conducted by Arlene Laliberté; the review of school-based programs was carried out by Brenda Simpson. We thank all of the contact persons who gave us further information about the reviewed programs. Liz Roberts at the Canadian Public Health Association and Natacha Joubert at Health Canada were especially helpful in collecting resource materials. We would also like to thank Susan Soule, Brian Mishara, Michel Tousignant, and Michael Kral for helpful comments on an earlier draft of this document. Sections of this report have been adapted from Kirmayer et al. (1993, 1996, 1998) and Kirmayer (1994). The document was translated into French by Suzanne Taillefer, Louise Veilleux, and Claude Taillefer.

This work was supported by a grant from the Conseil québecois de la recherche sociale (Native Mental Health Team).

Montreal, July 1999

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Summary

This report sets out a rationale and guidelines for suicide prevention in Native communities. Suicide prevention must be part of a larger, multi-faceted mental health promotion strategy that is the responsibility of the whole community, band or region. A comprehensive program requires a central coordinating group to insure there are no gaps in the system and to avoid duplication of efforts.

Primary suicide prevention strategies for Aboriginal communities should include:

1) training youth to act as peer counsellors;
2) a school curriculum with mental health and cultural heritage components;
3) recreational and sports programs;
4) workshops on life skills, problem solving, and communication;
5) parenting skills workshops;
6) support groups for individuals and families at risk;
7) cultural programs for the community at large;
8) collaboration between community workers in health, social services and education; and
9) training in mental health promotion for lay and professional helpers.

Intervention services should form part of the prevention strategy and include:

1) training of primary care providers;
2) development of a regional crisis hotline;
3) development of a crisis centre;
4) availability of immediate crisis intervention; and
5) assessment and intervention services for parents of youth at risk.

There is also a need for postvention services to help family and friends cope with a loss due to suicide. The overall prevention strategy and its major elements should be systematically evaluated. The results of ongoing evaluation can be used to identify useful or detrimental aspects of the strategy, uncover gaps or new possibilities for prevention, and refine the programs.

Resumé

Ce rapport énonce la raison d'être ainsi que les directives pour prévenir le suicide chez les communautés autochtones. La prévention du suicide doit faire partie d'une stratégie de promotion de la santé mentale, plus globale et d'aspects multiples, qui relève de la responsabilité de toute la communauté, de la tribut ou de la région. Un programme bien élaboré requiert un groupe de coordination centralisé afin d'assurer qu'il n'y ait aucune lacune dans le système et afin d'éviter une répétition inutile d'efforts.

Les stratégies fondamentales pour la prévention du suicide chez les communautés autochtones devraient inclure:

1) la formation des jeunes afin qu'ils puissent agir comme conseillers auprès de leurs pairs;
2) un curriculum scolaire incluant des notions de santé mentale et d'héritage culturel;
3) des programmes récréatifs et sportifs;
4) des ateliers d'habiletés en matière de vie quotidienne, de résolution de problèmes et de communication;
5) des ateliers d'habiletés parentales;
6) des groupes de support s'adressant aux individus et familles à risque;
7) des programmes culturels pour la communauté en général;
8) la collaboration entre les travailleurs communautaires œuvrant dans le domaine de la santé, des services sociaux et de l'éducation; et
9) de la formation de travailleurs profanes et professionnels en santé mentale.

Les services d'intervention devraient faire partie des stratégies de prévention et inclure :

1) la formation des intervenants de première ligne;
2) le développement régional d'une ligne d'écoute de crise;
3) l'élaboration d'un centre de crise;
4) l'accessibilité immédiate à une intervention de crise; et
5) des services d'évaluation et d'intervention destinés aux parents de jeunes à risque.

Il existe aussi un besoin de services de suivi afin d'aider la famille et les amis à faire face à un décès dû à un suicide. La stratégie globale d'intervention et ses principaux éléments devraient être systématiquement évalués. Les résultats d'une telle évaluation pourraient être utilisés afin d'identifier les aspects positifs ou négatifs de la stratégie, en identifier les lacunes ou de nouvelles possibilités de prévention, et améliorer les programmes.

1. Introduction

Suicide is one of the most dramatic and painful outcomes of suffering. The immediate cause of suicide for an individual is usually intense psychological pain, and a desire to escape from intolerable circumstances. Anger and frustration may also fuel suicidal behaviour. For suicide to occur, it must seem to be a viable option, alternatives to reduce pain or escape from the situation must be blocked, and the means for suicide must be available.

Conventional mental health approaches to suicide emphasize the identification and treatment of individuals at risk. This is one essential component of any effective intervention. Many Native communities are underserviced and it is not always possible for individuals with depression, substance abuse problems, and family crises to obtain appropriate help. Basic services must be made accessible to Aboriginal people living in remote communities and in urban centres. At the same time, the very high rates of suicide, attempted suicide and suicidal ideation among youth in many Native communities indicate that the problem is not just individual but involves community-wide issues. As such, a community-based approach to prevention is essential.

This report will set out the rationale and guidelines for a community-based prevention program that is likely to be effective. The first section briefly outlines the levels and types of prevention. The next section reviews the major risk and protective factors for suicide that inform prevention programs. The third section reviews the elements of suicide prevention programs that have been shown to be effective. The final two sections present program guidelines and recommendations. The recommendations are based on a systematic review of suicide prevention and mental health promotion programs developed for or potentially applicable to Native populations. To locate information about these programs, the following procedures were used:

- database searches at McGill University and Université de Québec à Montréal (UQAM) libraries, and at the Centre de Recherche et d'Intervention sur le Suicide et l'Euthanasie (CRISE) at UQAM;

- contact with personnel at the Cree Public Health Module, American Indian/Alaska Native Community Suicide Prevention Network, B.C. Council for Families, the Canadian Public Health Association, the Canadian Mental Health Association, Health Canada, and the World Health Organization;

- use of resources on First Nations and Inuit health programs available from the National Clearinghouse Catalogue, Health Programs Support Division, Medical Services Branch, Health and Welfare Canada;

- use of manuals, guides, reports and newsletters from organizations and the Royal Commission on Aboriginal Peoples (see list of resources used in Appendix C1).

Although other types of programs were included, effort was concentrated on finding programs:

1) developed by, adaptable to, or operating in Aboriginal populations;
2) developed for or adaptable to rural or remote communities;
3) incorporating measures targeted toward youth;
4) offering broad objectives that promote mental health in general; and
5) adhering to guidelines presented in this document.

Both school-based and community-based programs were sought, and we attempted to locate a wide range of programs that involve different target groups. A total of 29 programs were reviewed. Based on the review of these programs and their evaluation results (if available), 9 were chosen as appropriate models for Native communities who wish to use a pre-existing program. These recommended programs are described in some detail in Appendix A, along with contact names and addresses for more information. Brief descriptions and contact information for all of the reviewed programs are found in Appendix B. Appendix C provides bibliographic listings of the resources used to review the programs, recommended guides on program evaluation, and guidelines for conducting ethical research.

2. Levels of Prevention

Primary prevention aims to reduce suicide risk by improving the mental health of a population. Ideally, this kind of prevention strategy influences a number of social or mental health problems (Mental Health Branch, 1997). Examples include life skills education in schools, parenting programs and provision of accessible and effective mental health services for a population (Lester, 1997).

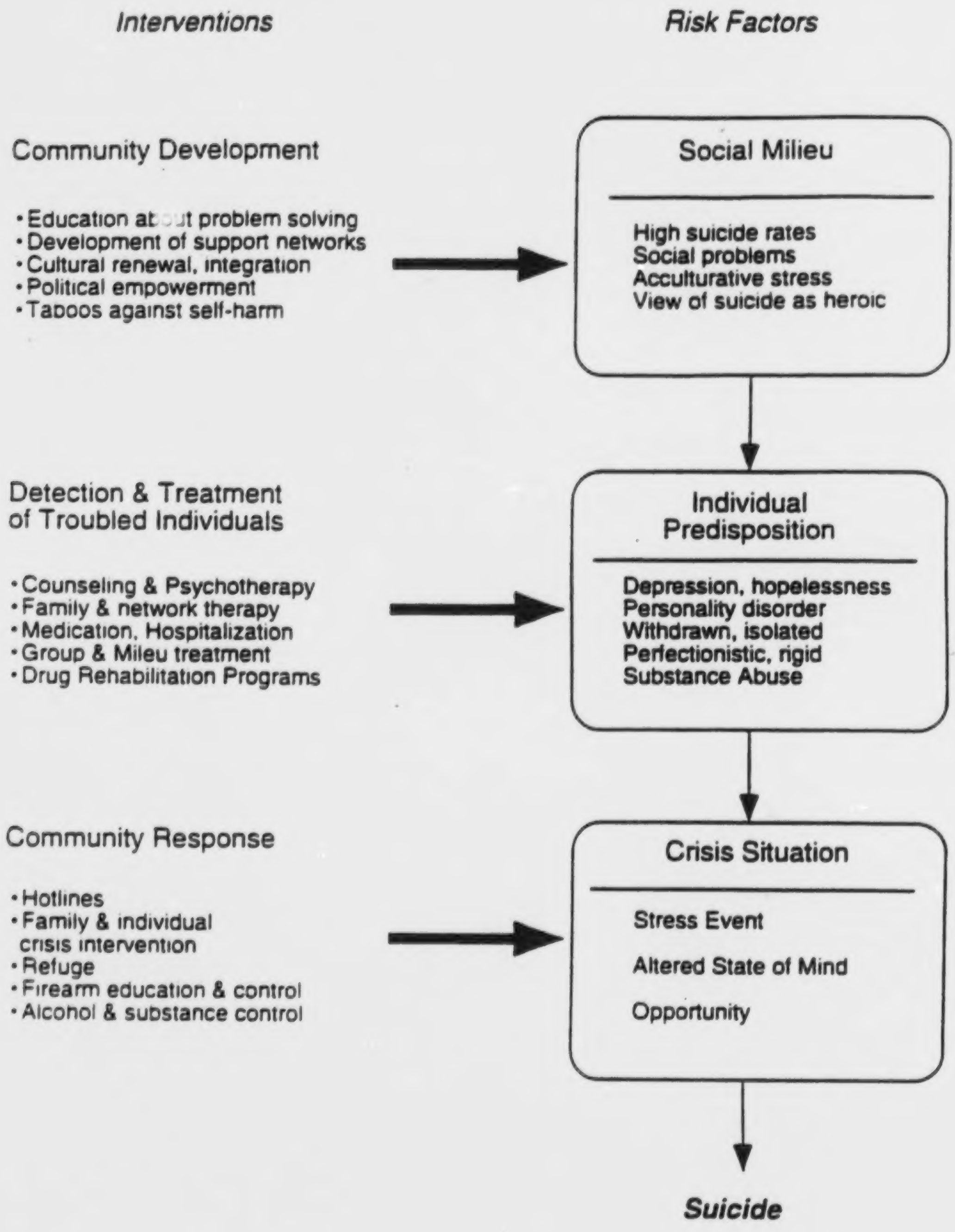
Secondary prevention (early intervention or treatment) aims to intervene with potentially suicidal individuals either before they injure themselves or during a suicidal crisis (Mental Health Branch, 1997). Examples include distress telephone lines as well as counselling and close supervision of persons who have spoken of suicidal intent.

Tertiary prevention (or *postvention)* focuses on persons who have been affected by suicidal behaviour: suicide attempters, who are at high risk for a recurrence, and bereaved friends or family members, who are also at risk for increased distress, psychiatric morbidity and the development of suicidal tendencies; this is often accomplished through counselling and other forms of support (Kirmayer et al., 1993).

Suicide prevention methods can be targeted at different levels: the sociocultural milieu and community level, the family, the vulnerable individual or the crisis situation, as shown by Figure 1 (Kirmayer et al., 1993). There is general agreement that programs directed to several of these levels at the same time will get the best effects. However, some areas may be more amenable to intervention than others in a given community.

There is controversy in the area of prevention as to whether to attempt to influence a whole population or to screen for and target high risk groups (Rose, 1992). In the case of most Native communities, their small size and the high prevalence of attempted suicide makes a community-wide approach most appropriate. This has two added advantages: (1) it avoids stigmatizing a specific group of individuals, and (2) it fits with broader goals of community development which will have a positive effect on the mental health of the whole population as well as vulnerable individuals.

Figure 1. A Model For Suicide Prevention*


Interventions
Risk Factors
Community Development
•Education about problem solving
•Development of support networks
•Cultural renewal, integration
•Political empowerment
•Taboos against self-harm
Social Milieu
High suicide rates
Social problems
Acculturative stress
View of suicide as heroic
Detection & Treatment of Troubled Individuals
•Counseling & Psychotherapy
•Family & network therapy
•Medication, Hospitalization
•Group & Mileu treatment
•Drug Rehabilitation Programs
Individual Predisposition
Depression, hopelessness
Personality disorder
Withdrawn, isolated
Perfectionistic, rigid
Substance Abuse
Community Response
•Hotlines
•Family & individual crisis intervention
•Refuge
•Firearm education & control
•Alcohol & substance control
Crisis Situation
Stress Event
Altered State of Mind
Opportunity
Suicide

* Based in part on Shaffer et al., 1988.

3. Risk and Protective Factors for Suicide

An understanding of the risk factors associated with suicidal behaviour should inform prevention strategies. A large number of factors show an association with suicide, reflecting the complexity of the issue. Most of these factors are not unique to First Nations and Inuit populations but may be more common or more severe in some Aboriginal communities. They can be classified into the following five areas, adapted from the Royal Commission on Aboriginal People's *Special Report on Suicide among Aboriginal People* (RCAP, 1995):

> ***Psychobiological factors***: e.g., mental illnesses, such as depression, anxiety disorders, conduct disorders and schizophrenia; 'cognitive style,' such as negative or inflexible thinking and difficulty in solving problems; and, certain temperamental or personality traits such as hypersensitivity, withdrawal and impulsiveness (Kirmayer et al., 1993; RCAP, 1995; Mental Health Branch, 1997).
>
> ***Life history factors***: e.g., trauma early in childhood due to disrupted relationships with caregivers, unexpected death in the family, sexual and physical abuse; chronic family instability and multiple home placements; family dysfunction and breakdown; conflict and rejection in significant relationships; criminal justice encounters; substance abuse; lack of religious and/or spiritual connections; family history of mental illness; and, prolonged or unresolved grief.
>
> ***Situational factors***: access to methods of self-injury such as firearms and medication (Kirmayer et al., 1993; Kirmayer, 1994; RCAP, 1995).
>
> ***Socioeconomic factors***: e.g., poverty at the individual and family level; community instability or lack of prosperity; limited opportunities for employment; and, lack of proper housing and inadequate sanitation and water quality, leading to high levels of infectious disease (RCAP, 1995).
>
> ***Culture stress***, defined as "the loss of confidence by individuals or groups in the ways of understanding life and living (norms, values and beliefs) that were taught to them within their original culture(s), and the personal or collective distress that may result" (RCAP, 1995, p.21). This includes loss of control over land and living conditions, breakdown of cultural values and belief systems, loss of identity and self-esteem, and discrimination.

More complete lists can be found in Kirmayer (1994) and MSSS (1998).

Among the protective factors that can act to decrease the risk of suicide include (Mental Health Branch, 1997, p.32):

1) a strong sense of the value and meaning of life
2) individual and collective self-esteem
3) belief in survival and coping
4) fear of suicide and moral objections to suicide
5) skills in stress management, communication and problem solving
6) support from peers and family
7) family responsibilities
8) community support networks
9) a sense of belonging.

There are specific developmental issues in adolescence and young adulthood that contribute to making this age group most vulnerable to suicide in Aboriginal communities. Youth are involved in gradual differentiation from their families of origin and the development of a network of peer relationships. When families have been troubled, this process of separation can be complicated and tumultuous. In many Native communities, youth face economic uncertainty with limited jobs and opportunities so that they may have few positive expectations for the future. Through mass media, they are confronted with images of a global youth culture that seems to enjoy great freedom and material wealth. This somewhat illusory image may be in stark contrast to the realities they see out their windows. Most importantly, the transmission of cultural tradition and identity has been disrupted by generations of cultural oppression. As a result, the processes of initiation and integration into adult society that once gave to youth a sense of their past and a valued role in the community have been replaced by the improvised attempts of peer groups to create a sense of belonging and identity.

Chandler and Lalonde (1998) have shown that local control and the preservation and continuation of culture among the 196 Native bands of British Columbia are associated with substantially lower youth suicide rates. Thus 'cultural continuity' may contribute to a sense of self-continuity which may be vital for adolescents passing through a time of great personal change. Community interventions that promote collective identity, sense of belonging, and a positive view of the future, with a clear role for youth, will likely have a strong impact on reducing suicide.

Anything that reduces a risk factor or increases a protective factor will help to prevent suicide. Although most research and practice focuses on individual factors, it is very likely that there are community-level factors that have powerful effects. To identify these factors, we need more studies that compare communities with low and high rates of suicide.

4. Elements of Effective Suicide Prevention Programs

Ideally, a suicide prevention program for Aboriginal communities would meet the following criteria:

- proven effectiveness
- reach high risk groups
- feasible given local resources
- address both immediate and basic, long-term causes.

There are relatively few studies evaluating the effectiveness of suicide prevention programs. In a review of evaluative research on suicide prevention across Canada, Breton and colleagues (1998) found 15 studies, most of which assessed the effectiveness of school-based programs. Most evaluations found benefits from the programs, but few studies had been published in the scientific literature. The report concluded that there is much need for further evaluative research and that this should focus not only on effectiveness but also examine the appropriateness of interventions, and their impact both on the specific factors that have been targeted and on the wider health care and social systems. The report also noted that the tendency to focus on one sector (e.g. school) did not reflect the reality of youths' experience which cuts across different professional domains and thus, demanded a more integrated and ecological approach.

There have been very few systematic evaluations of suicide prevention efforts in Aboriginal communities. Recently, the US Centers for Disease Control (CDC, 1998) published a report of the evaluation of a program implemented in 1990 among an Athabaskan tribe in rural New Mexico that was suffering from a high rate of suicide among youth (aged 15-19 years). The prevention and intervention program had many facets and included providing mental health and social services that were previously unavailable in the community, as well as measures directed to youth, and implementation of the CDC guidelines for containing suicide clusters. The program consisted of—

1) School-based "natural helpers" involving 10-25 youth each year who were trained to respond to young people in crisis and to notify mental health professionals of any need for assistance. These natural helpers also provided school and community education on alcohol and drug prevention, self-esteem and team building, and suicide prevention.
2) Outreach to families after a suicide or traumatic death or injury.
3) Immediate response and follow-up for youth reported to be at risk.
4) Community education about suicide prevention.
5) Suicide risk screening in mental health and social service programs.

The level of suicidal acts among youth 15-19 years was dramatically reduced almost immediately after the implementation of the program and this improvement was sustained over the following 5 years. However, there was no comparison community and it is possible that the observed improvement reflected cyclical trends in suicide over time. As well, the numbers of completed suicide were too small to demonstrate a clear effect of the program.

Nevertheless, at present, this is the best tested program and illustrates all of the principles to be included in an effective community-based approach (see Appendix A1).

A similar strategy was implemented in many Alaska Native communities in 1988 (see Appendix A2). The Community-Based Suicide Prevention Program provides grants to communities state-wide to support community-based activities such as cultural heritage instruction, support groups, recreational activities, volunteer helping systems, counselling, and crisis response. Forty-eight communities received grants in the first year, and this number grew to 66 in 1995 (20 maintained their projects continuously over this period). Each community has implemented one or more projects from a wide range of potential approaches. An evaluation from 1989 to 1993 found that while project communities began with higher suicide rates than the overall Alaska Native rate, their rates declined faster than the state-wide rate at the end of 3 years. It appears that communities that have been able to sustain their programs over several years have had the best outcomes (S. Soule, *personal communication*, February 1999).

Each band or community will have its own view of the priorities and preferred course of action with regard to a suicide problem (RCAP, 1995). The goal of this section, however, is to provide information about key elements that appear to be associated with successful approaches in Aboriginal settings. Case studies presented in the RCAP *Special Report*, as well as other sources in the literature, support several conclusions about what works at the various levels of prevention, as summarized in the following subsections.

4.1. Primary Prevention Strategies

The RCAP report provides case studies of five programs: (1) the Ngwaagan Gamig Recovery Centre for alcohol/drug addiction and Nadmadwin Mental Health Clinic, Wikwemikong, Ontario; (2) the 1993 Big Cove gathering and community sharing circle, New Brunswick; (3) a suicide prevention training program for community caregivers, Northwest Territories; (4) the Canim Lake family violence program, British Columbia; and (5) the Wakayos Child Care Education Centre, Meadow Lake, Saskatchewan. These case studies serve to highlight factors that contribute to successful mental health promotion strategies among Aboriginal people. The activities were community-initiated (some in conjunction with band councils or regional Aboriginal organizations), drew from traditional knowledge and wisdom of elders, were dependent on consultation with the community, and were broad in focus. Most involved locally-controlled partnerships with external groups. Strategies aimed at community and social development should promote community pride and control, self-esteem and identity, transmission of Aboriginal knowledge, language and traditions, and methods of addressing social problems that are culturally appropriate (Kirmayer et al., 1993; RCAP, 1995).

School-Based Suicide Prevention Programs

According to the World Health Organization, "school health programmes can simultaneously reduce common health problems, increase the efficiency of the education system and advance public health, education and social and economic development in each nation" (WHO Press Office Fact Sheet, No. 92, Rev. June 1998). This underscores the benefits of school-based health promotion which, in turn, provides the basis for preventive care.

The current consensus in the literature on youth suicide prevention emphasizes that rather than teaching the topic of suicide exclusively to students, schools should provide a health education curriculum for all students that builds basic skills useful for managing a variety of health and social issues (Kirmayer et al., 1993). Such a curriculum would enhance ability to cope with stress or distressing emotions, problem solving, interpersonal communication and conflict resolution—all measures that help to build self-esteem and deal with emotional conflict and crisis (Cimbolic & Jobes, 1990).

The steps for setting up a successful school-based awareness program include (White & Jodoin, 1998):

1) gain entry to the relevant youth-serving systems
2) select a curriculum
3) provide suicide prevention training for school personnel
4) develop school policies and procedures
5) develop and maintain linkages with the community mental health system.

In school programs, short information sessions on suicide for students should be avoided in favour of discussion of suicide in the context of developing life skills and self-esteem, problem solving, and communication skills (RCAP, 1995; Tierney, 1998). Many young people do not recognize suicide as a feature of a mental illness, but rather as a natural or even heroic response to rejection. This misconception, as well as perceived stigma against psychiatric help, can prevent help-seeking for mental distress and illness (Shaffer et al., 1988). Educational materials aimed at facilitating appropriate help-seeking for major depression, alcohol or substance abuse, and family problems may help reduce the risk of suicide. As pointed out in the section on risk and protective factors, knowledge of Aboriginal culture and pride in one's roots and heritage are especially important for young people and can be promoted through cultural curricula.

Younger children (under the age of 12 years) are also an important target group for primary prevention, since many contributors to youth despair begin to have an effect during childhood. This implies attention to and support for the family. Family life education, family therapy or social network interventions aimed to uncover abuse, resolve conflicts and ensure the emotional support of youth and children may be more useful than an individual approach centred on the young person (Kirmayer et al., 1993).

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Cultural Promotion and Community Development

For the community at large, information about suicide should be transmitted along with information about mental illness, help-seeking resources, and ways of dealing with substance abuse, anger, relationship break-ups and emotional distress (Kirmayer et al, 1993). At the same time, education programs should be sensitive to the fact that suicidality has specific indicators and patterns (RCAP, 1995; see next section on early intervention).

Community caregivers should receive mental health training and develop skills in individual and family counselling, social network intervention, and community development. Primary care providers (doctors and nurses) need to be trained to better recognize and treat major depression and other psychiatric disorders (Kirmayer et al., 1993).

Although school is a natural focus for programs working with the age groups most strongly affected by suicide in Aboriginal communities, there are youth who have dropped out, families who are isolated, and older age groups who may not be reached. Community-based approaches address the need to reach the widest range of individuals and to have impact on the community as a whole with respect to social structures, collective self-esteem and shared vision.

Since breakdown in the transmission of cultural traditions appears to contribute substantially to the widespread demoralization and hopelessness of Aboriginal youth, the development of programs to transmit traditional knowledge and values, usually by respected elders, is also a crucial component of any suicide prevention program addressed to Aboriginal peoples (Kirmayer et al., 1993).

4.2. Early Intervention and Treatment

It is important to have direct suicide prevention responses ("crisis services") in place which allow identification of persons at immediate risk and intervention to prevent their self-injury or death (and possibly the injury or death of others) (RCAP, 1995). This implies having the human resources for management of a crisis situation as well as long-term support involving professional and/or lay caregivers, developed and set up before a crisis is under way. There must be ready access to culturally-sensitive mental health care, that is, health care that respects and is consonant with local, cultural values (Kirmayer et al., 1993). The response to a crisis situation in remote, isolated communities requires effective links to regional hospitals and training of potential support persons in each community. A "crisis center" able to accommodate short-term stays for crisis treatment may have some effectiveness, particularly if the centre is run by Aboriginal persons (Lester, 1997). Several Canadian suicide prevention centres have been set up to provide direct counselling as well as health promotion information.

Specific suicide education related to detection should be provided to teachers, social workers, health care professionals, clergy, police and other community members who are likely to come in contact with high risk individuals (RCAP, 1995). Those closest to a person with suicidal intentions have the best chance of recognizing the "warning signs" and taking action (which will usually mean referral to a trained professional). Thus, parents as well as other community members such as young people can benefit from basic training in recognizing the clues and knowing when (and how) to get help for someone in danger of self-injury (RCAP, 1995). Distressed youth turn more often to their friends for help instead of family members or professionals in the community (Malus et al., 1994; Tierney, 1998). Health care providers must also be trained to recognize the signs of a suicidal individual in order to offer timely treatment.

Certain psychotherapy-oriented mental health interventions for high risk individuals may not fit well either with traditional Aboriginal values or contemporary realities of settlement life. Family and social network approaches may be more consonant with Aboriginal culture, particularly if they are extended to incorporate some notion of the interconnectedness of person and environment (LaFramboise, 1988; Fleming, 1994). Many indigenous peoples have a strong sense of how a person's mental and physical state depends on their relationship to the land and to animals. Although there has been rapid culture change and the perspective of young people is in many respects different than that of their parents and grandparents, these ideas and attitudes are still relevant and hold keys to cultural continuity and renewal that are important for the whole community. Direct involvement of elders as advisors and caregivers in the development of counselling methods and associated psychotherapeutic techniques is essential for the evolution of culturally-appropriate care that will also contribute to a valued sense of collective identity (Duran & Duran, 1995).

Crisis telephone lines have had limited impact in the general population but may have more value in small, remote communities if other sources of help are scarce. The first successful crisis line in the North, Kamatsiaqtut (Baffin Crisis Line), is operating in Nunavut (Levy & Fletcher, 1998). This telephone service was developed in the early 1990s by community members, and provides counselling and contact services for anyone in need. Community ownership has been essential for success of the program: the service is delivered entirely by volunteer Northerners and has as many Inuktitut speakers as possible on the lines (about 80% of the population being served is Inuit). The program was developed using Southern crisis line models, adapted to the local setting and culture, and strict rules are used to maintain anonymity and confidentiality. An average of three calls are received per night (the lines are open from 9 p.m. to midnight). The program has been expanded to service half of the Northwest Territories and a large portion of Quebec (in area code 819) toll-free; two other lines in the NWT have been developed based on this model. Such services can offer help with a level of confidentiality that may be impossible in many small communities.

Restricting access to lethal means of self-injury can make the difference between a death and the opportunity to help a distressed individual. Relatively easy access to firearms in many Aboriginal communities is likely unavoidable, although gun safety and proper storage can be promoted through education programs. Methods other than firearms are important in many communities. For example, a review of 68 suicide and possible suicide deaths in Nunavik during the time period 1982-1996 shows that the majority of deaths resulted from hanging, most often in the victim's bedroom using the closet rod. The installation of closet rods that give way under the weight of a person may interfere with this method (Masecar, 1998). A NWT community with very high suicide rates removed closet rods and bedroom door locks in the early 1990s. Although other prevention activities occurred around the same time, such as multiple community meetings, the suicide rate dramatically decreased over the next several years (M. Kral, *personal communication*, March 1999).

4.3. Postvention

It is essential to provide aftercare services for those who have made a suicide attempt or show other tendencies for self-injury, as such individuals are at high risk for completing suicide at a later time. The forms of support should include both appropriate clinical services to treat psychiatric illness and non-medical approaches to mental health and healing (examples include peer counselling, close supervision, and counselling by elders) (Mental Health Branch, 1997). Services need to be accessible and meaningful for persons who "may be in conflict with the law, have issues with substance use or sexuality, or be otherwise alienated from helping services" (Mental Health Branch, 1997, p.42).

Support also needs to be in place for family and community members affected by a suicide attempt or death. Suicide has significant impact on family and friends of the victim, increasing depression for at least six months after the event. Many authorities advocate the provision of counselling aimed at promoting normal mourning and avoiding pathological grief responses (Kirmayer et al., 1993). In order to respond in a timely fashion to a suicide, it is important to have essential services and a coordinating team in place. The CDC (O'Carroll, Mercy & Steward, 1988) has provided guidelines for postvention services, with particular attention to responding to suicide clusters.

The publicity given to suicides may contribute to suicide clusters (Kirmayer, 1994). Suicide commands public and government attention and is often perceived as a powerful issue to use in political debates. This focus, however, can inadvertently legitimate suicide as a form of political protest and thus increase its prevalence. Research has shown that reports on youth suicide in newspapers or entertainment products have been associated with increased levels of suicidal behaviour among exposed persons (Phillips & Cartensen, 1986; Phillips et al., 1992).

Both national and local media have a responsibility to take great care with their coverage of suicide issues by adhering to codes of conduct (RCAP, 1995; United Nations, 1996). Suicidal behaviour must not be dramatized or romanticized, and details on methods should not be provided. A news report should always be accompanied by information about available suicide prevention resources (Centers for Disease Control, 1988) and other means of coping with distress (RCAP, 1995). This can be presented in the form of comments by persons who were previously suicidal but sought help or by caregivers who can offer assistance (Mental Health Branch, 1997). The media can contribute to suicide prevention by presenting positive images of Native culture and examples of successful coping and community development.

5. Guidelines for Effective Suicide Prevention

In its *Special Report on Suicide*, the RCAP argued that only a comprehensive approach to suicide prevention will improve the situation in Aboriginal communities. Such an approach includes plans and programs that:

- provide suicide crisis services
- promote broad preventive action and community development
- address "long-term needs for self-determination, self-sufficiency and healing" (RCAP, 1995, p.75).

A suicide prevention strategy with the best chance of making a difference is better conceptualized as a "mental health" or "community wellness" promotion strategy. This suggests the following general guidelines for a suicide prevention strategy:

1) Suicide prevention should be the responsibility of the entire community, requiring community support and solidarity among family, religious, political or other groups. Given the importance of community, there is a need for close collaboration between health and education services. The bureaucratic structures that have evolved in government and urban services are fragmented and sometimes competitive. This can have disastrous effects in Native communities.

2) A focus on children and young people (up to their late 20s) is crucial, but this implies involvement of the family and the community.

3) The problem of suicide must be addressed from many perspectives, encompassing biological, psychological, sociocultural and spiritual dimensions of health and well-being.

4) Programs that are long-term in focus should be developed along with "crisis" responses. A comprehensive approach to the problem of suicide should be integrated within larger programs of health promotion, family life education, community and cultural development, and political empowerment.

5) Evaluation of the impact of prevention strategies is essential. The fact of a program's continued existence is often taken as an indicator of its success. While this may be true, it is always important to examine the workings of a program and its wider impact to detect any unforeseen or harmful effects.

6) Programs should be locally-initiated, owned and accountable, embodying the norms and values of Native culture. Training of community mental health workers in individual and family counselling (particularly for grief), appropriate social intervention and community development methods is essential. Although it is crucial to develop local solutions, rather than those imposed by external agencies, useful

help from the latter should not be rejected when a partnership can be productive.

The Quebec Ministry of Health and Social Services (MSSS, 1998) has prepared a strategy for preventing suicide based on the following principles:

1) enhance the meaning of life through a sense of community and responsibility;
2) acknowledge that the individual and society have certain skills for dealing with suicide, and the potential to develop new ones; and
3) count on existing caseworkers and services.

While many of the goals and objectives are pertinent to Aboriginal communities, most require some modification or reconsideration to fit the social and cultural realities. Below, we list each of the objectives of the Quebec strategy with comments on their pertinence to Native populations and communities.

Provide and consolidate essential services and put an end to the isolation of caseworkers.

Many Native communities lack access to basic mental health services. Essential services include access to help by telephone on a 24-hour basis, skilled intervention (full assessment, treatment and follow-up) for suicide and related mental health problems, and postvention. To be useful this help should be available in a language the client is comfortable with, and take into account cultural and social aspects of their background and milieu.

Mental health workers in remote settlements may experience more isolation than their counterparts who work in cities. Workers in remote communities are typically related to many of their clients and operate without the backup of other professionals and resources needed to deal with crises (e.g. supervised settings, psychiatric consultation, day-hospital programs, family intervention). There is often a division between school, social services and health sectors even in small communities. This must be counteracted to provide support for workers and continuity of care.

Increase professional skills.

Clinicians and helpers must be trained to be able to detect and respond to potentially suicidal individuals. This applies especially to gate-keepers like staff at school and primary care providers. The ability to recognize problems depends, in part, on the clinician's confidence in treatment. Treatment skills are particularly important for nurse practitioners and family physicians who work in remote communities where there is little specialized mental health service available. Areas where additional training in treatment approaches may be needed include major depression, anxiety disorders, substance abuse, family violence, and sexual abuse.

Given the lack of trained mental health workers in many Native communities, and the crucial importance of cultural and linguistic knowledge in treatment, it is essential to extend training programs to local community workers, healers, church leaders and other "natural" helpers. Professional training can be adapted to the needs and perspectives of these groups so that they can both provide various types of supportive intervention and work with professionals when necessary.

Intervene with groups at risk.

Many Aboriginal communities represent groups at risk by reason of their history and social circumstances. Young men, in particular, constitute an identifiable group at risk. Substance abuse, particularly alcohol abuse and any history of solvent use, are strong indicators of increased risk. Solvent abuse often occurs among pre-adolescents and points toward significant individual and family problems. However, epidemiological studies show that the prevalence of suicidal ideation is so widespread among young people in some communities that the concept of an 'at risk group' may be misleading and a broader community-based approach is needed.

Foster promotion and prevention programs among young people.

Since many suicidal youth do not contact any professionals or adults when they are in crisis, training of peers to detect and respond to problems is crucial. Programs for youth should foster self-esteem and social skills, develop specific suicide prevention expertise, and provide postvention for young people who have lost a friend or family member through suicide. These programs can be school-based but must be adapted to reach out to the most vulnerable youth who may not attend school.

Peer support programs—in which trained student volunteers head and run the program—offer an appealing alternative to conventional suicide awareness lectures, because they may make resources more readily available to other students. Awareness programs may be less useful in many Aboriginal communities, where the population is all too aware of suicide, although there remains a need to correct misconceptions. In particular, for some youth, suicide may be viewed positively as an effective means of protest or a heroic gesture pointing to social wrongs and injustices. Suicide education can challenge this romanticized view of suicide and point to alternative responses to interpersonal crises and despair. In general, getting youth actively involved in helping others, and in community organizations, is likely to be more effective than simply offering them "education." When despair (even in its mildest form, as boredom) affects a whole generation of young people, it may be necessary to involve a large number of youth directly in teaching, helping, and community activities to have significant impact.

Reduce access to and minimize risks associated with the means of suicide.

The major means of suicide to be controlled include hanging, firearms, medications, and carbon monoxide. Control of these means is difficult in most Aboriginal communities. Hanging requires no special equipment. Firearms are readily available and important equipment for traditional hunting activities. Education of families to secure firearms, medications and other dangerous substances may introduce a crucial delay between suicidal intention and action, that allows the upset person to 'cool off'.

There is a high rate of accidental death in many Native communities, some of which may be related to risk taking and self-destructive behaviour (e.g. skidoo or ATV accidents due to recklessness and drug or alcohol use). Some authors have suggested that many such accidents can be considered to be a form of suicidal behaviour (Young, 1994). Education and safety programs may reduce these accidents; conversely, effective suicide prevention should also reduce the frequency of accidental death.

Counteract the trivialization and sensationalization of suicide by developing a sense of community and responsibility.

There are prevailing attitudes in some segments of society that romanticize suicide as an expression of alienation, protest or heartbreak. Mass media sometimes make suicide the topic of sensationalized accounts. For Native people, in particular, suicide has come to represent the effects of cultural suppression and marginalization, which may inadvertently give it heroic meaning for some youth. Suicide prevention requires strengthening individual and community attitudes that abhor suicide. Skillful problem solving, involvement in the community and political activism all represent alternatives to self-destructive despair that must be taught and valorized.

Intensify and diversify research.

As noted earlier in this document, there is a lack of research on suicide among Native communities. While there is some information on risk and protective factors at an individual level, little is known about the factors that affect whole communities. This requires studies that compare multiple communities. Such research can identify factors that contribute to community and individual wellness.

There is an urgent need for research to evaluate suicide prevention and mental health promotion programs in terms of effectiveness, feasibility and wider social impact. Outcomes to be evaluated can include suicide attempts and ideation, but also other forms of self-destructive behaviour, psychological distress, school performance, and service utilization.

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Research has often been perceived in Native communities as another form of exploitation or external control (O'Neil, 1998). Projects must be designed and carried out with the full partnership of Native communities. Every project presents an opportunity for the transfer of knowledge of research methods and skills to community members so that they can initiate, carry out and locally control their own evaluative research.

Research in Native communities poses special ethical concerns. The small scale of communities makes it difficult to ensure confidentiality and anonymity. A research project can have significant impact on the whole community. Images of the community portrayed through the research may affect subsequent well-being. All of these issues require careful attention. Guidelines for ethical research in Native communities have been developed that address these basic concerns. The Royal Commission on Aboriginal Peoples (RCAP, 1993) presents a thorough set of guidelines as part of an Integrated Research Plan. A highly recommended document, prepared for a "responsible research" workshop in the NWT, explores community-based research concerns for Aboriginals in a detailed and clearly written manner (Dene Tracking, 1993). Two other documents were specifically prepared for Inuit communities, but raise issues relevant to other Native groups (Inuit Tapirisat, 1993; Inuit Circumpolar Conference, no date). Appendix C3 at the end of this document lists useful documents that address ethical issues.

6. Recommendations

Here we list specific tasks for a comprehensive community-based suicide prevention program. Many of the suggestions are linked to detailed descriptions of recommended programs in Appendix A. If pre-existing models are used, programs will require careful adaptation to the specific situation of each community.

6.1. Overall Orientation

Suicide prevention should be understood as part of a larger, multi-faceted mental health promotion strategy that is the responsibility of the whole community, band or region.

6.2. Planning and Coordination

A comprehensive suicide prevention program requires a central coordinating group to insure there are no gaps in the system and to avoid duplication. This group should involve representatives from major sectors of the community: youth, elders, caregivers, professionals (from health, social services, and education), local government, and others. Inter-agency collaboration should be encouraged in order to fully utilize the strengths of all concerned, resulting in a comprehensive strategy, responsive to the changing needs of individuals and the community. Together they may create or adapt programs that reflect the true nature of the community. The immediate effect of such collaboration will be a coordinated response to suicide prevention. The long-term effects will be the strengthening of the community and cultural identity, as well as the emergence of local control which will improve the health of both individuals and communities.

This coordinating group should also link with and supervise a research team who can help design and carry out evaluations of the prevention activities and programs.

6.3. Prevention

Primary suicide prevention strategies for Aboriginal communities should include the activities listed below:

1) Peer counselling in which a group of youth are trained in basic listening skills and are identified as resource people for other youth in crisis (see Appendix A1, A6).

2) A school curriculum that incorporates learning about positive mental health, the recognition of suicide, substance use, and other problems as serious mental health issues, as well as cultural heritage as a source of ways of healthy coping (A3, A4).

3) Recreational and sports programs for children and young people to combat boredom and alienation and foster peer support and a sense of belonging (A2).

4) Workshops on life skills, problem solving, and communications for children and young people; much of this can be given by youth counsellors who will provide positive role models (A1, A5, A6, A9).

5) Family life education and parenting skills workshops for new parents and adults (A7, A8).

6) Support groups for individuals and families at risk (e.g. young mothers, recovering substance abusers, ex-offenders who have returned to the community after serving time) (A2).

7) Cultural programs and activities for the community at large (e.g., recording and transmitting the traditions of elders, camping on the land, ceremonial feasts, Aboriginal language courses) (A2).

8) Collaboration between community workers in health, social services and education to promote integration of services.

9) Training in mental health promotion and suicide risk factor awareness for lay and professional helpers (A1).

10) Opening lines of communication by creating opportunities for community members to express their concerns and interests (e.g. town council or community meetings and gatherings).

While many of these activities and programs can be implemented through the school or clinic, they would be greatly facilitated by the development of a community drop-in centre where these activities can take place.

6.4. Intervention

The following programs and services address the needs for intervention with individuals at high risk for suicide and should form part of a comprehensive prevention strategy:

1) Training of primary care providers (nurses, physicians, social workers, etc.) in suicide detection and crisis intervention as well as in treatment of depression, anxiety disorders, substance use, and other psychiatric disorders.

2) Development of a regional crisis hotline. This should be based outside the community to provide some confidentiality, but workers should have knowledge of the community in order to respond appropriately

and have community contacts who are available to intervene quickly when necessary.

3) Development of a crisis centre. This should be based in the community or in an adjoining community to provide a safe place, "time out", and an opportunity for intensive intervention. It can be staffed by lay helpers and "big brothers/sisters", with professional assistance available.

4) Immediate availability of crisis intervention for those at acute risk.

5) Development of assessment and intervention services for parents of youth at risk (e.g., individual, couple or family interventions for substance use, family violence, effects of residential school experiences and relocations, etc.).

6.5. Postvention

There is a need for routine follow-up of family and friends who have experienced a loss through suicide, to identify and help those at risk for suicide themselves.

Since Native communities are closely-knit and many youth find themselves in similar predicaments, suicides often occur in clusters. There is therefore a need to develop a crisis team to respond to suicide clusters. The U.S. Centers for Disease Control has developed guidelines for the community response to suicide clusters (O'Carroll, Mercy & Steward, 1988). In brief, these guidelines suggest:

1) A community should review these recommendations and develop their own plan before the onset of a suicide cluster.

2) The response to the crisis should involve all concerned sectors of the community:

    A) a coordinating committee of concerned individuals from school, church, health care, government, law enforcement, helpers, etc.
    B) a host agency should coordinate meetings, planning and actual response in time of crisis.

3) Relevant community resources should be identified, including: hospital, emergency medical services, school, clergy, parents' groups, suicide hotline, students, police, media, and representatives from agencies not on the coordinating committee.

4) The response should be implemented when a suicide cluster occurs or when one or more deaths from trauma are identified that may impact on the adolescents.

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5) The first step in crisis response is to contact and prepare all groups involved.

6) Avoid glorifying suicide victims and minimize sensationalism.

7) High risk persons should be identified and have at least one screening interview with a trained counselor and then be referred for further counseling as needed.

8) Timely flow of accurate, appropriate information should be provided to the media.

9) Elements of the environment that might increase the likelihood of further suicide attempts should be identified and changed.

10) Long-term issues suggested by the nature of the suicide cluster should be addressed.

These guidelines are relevant to suicide prevention in general.

6.6. Evaluation

An evaluation strategy should be developed from the start in parallel with program development. If necessary, this can be done in partnership with academic researchers who have the requisite expertise. Two handbooks on evaluation for First Nations and Inuit communities are recommended for detailed information (Health and Welfare Canada, 1991; Humanité Services Planning, 1993).

The overall prevention strategy and its major elements should be systematically evaluated in terms of

- effectiveness;
- feasibility and cost-effectiveness;
- process; and
- wider social and cultural impact.

The results of ongoing evaluation can be used to identify useful or detrimental aspects of the strategy, uncover gaps or new possibilities for prevention, and refine the programs.

Effectiveness can be assessed in terms of

- rate of attempted suicide and suicidal ideation through community surveys;
- service utilization through clinical records; and
- other epidemiological measures of mental health and well-being.

Basic outcome statistics include: mortality rates by suicide, by sex and by age; information on methods used; attempted suicide rate as estimated by a survey; and hospitalization rate following attempted suicide by sex and by age.

Evaluation of the feasibility and cost-effectiveness of programs is important to identify what elements are most readily transferable to other communities, as well as to seek support for long-term funding to maintain prevention efforts. Process evaluation that examines how a program was implemented, obstacles faced, and solutions found will provide essential information for further program development as well as potential assistance to other communities seeking to develop similar programs.

Finally, any prevention program with the wide scope described in these recommendations will have far-reaching effects on community life, individual and collective identity, and other social and cultural outcomes (e.g. economy). Qualitative and, where possible, quantitative analysis of this wider social impact will add a critical dimension to prevention efforts.

Appendix A. Recommended Programs

This appendix presents descriptions of the 9 programs we most highly recommend as suicide prevention and mental health promotion activities, based on our review of the 29 programs listed in Appendix B. We also provide contact names and addresses which can be used to obtain more information and/or order program materials.

A1. Jicarilla Mental Health and Social Services Program

This multifaceted prevention and intervention program was described in section 4 on page 14. The program, which began in January 1990, includes providing mental health and social services that were previously unavailable in the community, measures directed toward youth 15-19 years old, and implementation of the CDC guidelines for containing suicide clusters. The American Indian community involved is remote, with a young population and with the majority of residents unemployed and living in poverty. The suicide rate was 22 times the national U.S. average in the late 1980s.

The program uses a community-based, family-centred approach to suicide prevention, and emphasizes cultural values and traditions. It focuses on specific risk factors for suicide (alcohol and substance abuse, physical, sexual, and emotional abuse and neglect of children) and addresses community problems through education on domestic violence, child abuse, economics, sexuality, substance abuse, and parenting. The following components are supported by the program:

1) School-based "natural helpers" involving 10-25 youth each year who are trained to respond to young people in crisis and to notify mental health professionals of the need for assistance. These natural helpers also provide school and community education on alcohol and drug prevention, self-esteem and team building, and suicide prevention.

2) Outreach to families after a suicide or traumatic death or injury.

3) Immediate response and follow-up for youth reported to be at risk.

4) Community education about suicide prevention.

5) Training of teachers, school personnel, peer counsellors, emergency transportation staff and police in suicide risk assessment, and suicide risk screening in mental health and social service programs.

During 1993-94, suicide prevention activities were expanded to include community members between the ages of 20 and 24 years.

A surveillance system was implemented by local professional staff to collect information about suicide attempts and completions in the community. Rates of suicidal acts (attempts plus completions) among young persons 15-19 years old substantially decreased almost immediately after the implementation of this program, from 59.8/1000 population in 1988-89 to 8.9/1000 in 1990-91. This improvement was sustained over the following 5 years, with rates of 9.2/1000 (for 1992-93), 17.6/1000 (for 1994-95), and 10.9/1000 (for 1996-97).

The CDC suggests that aspects of the program that possibly contributed to the decrease in rates include multiple prevention and intervention strategies within a centralized population, and full-time program staff dedicated to suicide prevention. The decrease was observed despite more consistent surveillance and heightened community education about suicide and its prevention. Further evaluation of this program will be important, and should include a comparison of rates of suicidal acts within other tribal communities in New Mexico without such a program.

The Jicarilla Mental Health & Social Services program is part of the American Indian/Alaska Native Community Suicide Prevention Center & Network (AI/AN CSPCN). The focus of the network is to develop suicide prevention and intervention programs, crisis response teams, and information sharing between Native communities. A number of youth and adult Community Trainers from across the U.S. are available to help other Native communities develop crisis response, prevention activities, surveillance systems, team building, and program evaluation. The network is also establishing a newsletter, a manual for intervention/prevention programs, information gathering from other tribes with prevention strategies, and a reference library. In November 1998, a first National Conference was held by AI/AN CSPCN in San Diego.

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www.jade2.tec.nm.us/cspcn/cspcnfrm.htm (website)

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A2. Community-Based Suicide Prevention Program

The Community-Based Suicide Prevention Program (CBSPP) has been developed and implemented by Alaska Native communities. This program was described in section 4 on page 15. The CBSPP program is state-funded and provides grants to support community-based suicide prevention activities. These activities target different areas of the prevention spectrum, ranging from mental health promotion to suicide intervention and postvention. The grant application procedure is unique in that a local planning group must be formed in each community requesting funds, in order to determine the needs of the community, assist in completing the application, and oversee the program activities. Resource persons from outside the communities—known as Community Development Specialists—are available to assist in planning and developing the application.

One Community Development Specialist who worked in Southwest Alaska described the philosophy of CBSPP as follows:

> "These [self-destructive] behaviors require a different response by the health care system...When government and communities work together to improve the health care system, the result can produce a climate that encourages local empowerment and local responsibility. Using the community approach to prevention appears to produce this result" (Berger & Tobeluk, 1990; p. 293).

The Community-Based Suicide Prevention Program was developed in response to the very high rate of suicide among Alaska Natives in the 1980s. A 1987 resolution in the Alaska State Legislature established a Senate Special Committee on Suicide Prevention, and public hearings around the state received testimony including the following:

> "...the time has come for the villages to take responsibility for healing themselves and...village people must be trained to do the work. The State's role should be facilitative, providing on-going funds to village and tribal councils for locally determined, directed and staffed programs, and providing technical assistance and training as the village[s] request" (Coordinators' Handbook, p. 9).

A coordinators' handbook was produced in 1996 by CBSPP coordinators responsible for overseeing community activities. The handbook is divided into 4 sections: (1) *The CBSPP: What it is and what it is doing* includes a description of the program, how it began, and the program activities across the State of Alaska; (2) *Responding to suicidal behavior* presents the signs of suicide, crisis intervention, and dealing with losses and suicide; (3) *Taking care of yourself* discusses worker burnout, time management, and ethics for project coordinators; and (4) *Taking care of your project and your grant (administration)* covers the grant application process, program reports, workshops, community networking, and how to sustain a program. This handbook is well-written, uses simple terms, is experience based rather than theoretically oriented, and is user friendly. The basis of the CBSPP is a "grass-roots" strategy which involves the whole community, incorporates cultural values, encourages traditional activities, and takes a holistic approach to wellness.

The accomplishments of this program are impressive. It officially began in 1988, with 48 communities receiving grants in the first year. This number increased to 66 by 1995; 20 of these projects have been continuously maintained from the first year. There are currently 59 participating communities. The coordinators from different communities have developed an important network to support one another. They share vital information through a bi-monthly newsletter and hold annual coordinators' training conferences. Most communities have incorporated one or more of the following activity types in their program: (1) youth/elder communication (e.g. cultural instruction, support groups for youth or elders or both); (2) cultural projects (e.g. crafts, kayak building); (3) volunteer helping systems; (4) recreational activities (e.g. camping, kid's night, family night); (5) counselling; (6) crisis response; and (7) education/prevention.

Many of the projects supported by CBSPP focus on traditional activities that promote cultural values such as elder and youth exchanges, where the elders share their knowledge and wisdom with the younger generation. This kind of activity could have several forms, like a fishing trip or a sewing circle. These exchanges enhance the elders' self-esteem and teach respect to the youth, as they create a favorable climate to pass on important cultural knowledge. In addition, an interactive training CD-ROM entitled "Close To Home: Suicide Intervention in Rural Alaska" has been produced in collaboration with Yupiit Eskimo people from the Yukon-Kuskokwin River Delta. Sent to each CBSPP project in 1998, the CD-ROM teaches 5 steps of intervention using Aboriginal actors, images, voices and design.

The CBSPP program was independently evaluated from 1989 through the spring of 1993. The evaluation report states that:

> "(1) As a group project, communities began with higher suicide rates than the overall rate for Alaska Natives. At the end of three years, rates in project communities declined faster than state-wide Alaska Native rates;
>
> (2) Communities have used these projects to educate themselves about the problems of self-destructive behaviors and to develop on-going programs of sober activities and support groups;
>
> (3) In the five project communities studied in depth, there was an increase in the number of people who knew warning signs of suicide, and who knew how to refer an at-risk person" (Coordinators' Handbook, p. 10).

A Participatory Prevention Program Evaluation Project is currently underway, with the goal of understanding how CBSPP works and what results it achieves. An outside evaluator is working closely with a steering committee of coordinators and staff to determine which goals, objectives, activities, and target

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groups to track, and what impact information to collect (with respect to community-determined and external results).

As the CBSPP program is essentially a framework, it leaves room for community input and other components that make up the activities of a mental health promotion strategy. This is very important since the communities participating in the program can fit it to their needs; the community members, in turn, are empowered as they take control of their mental health. Given the availability of regionally-controlled funds, a strategy similar to Alaska's CBSPP could be implemented in Aboriginal regions of Canada; that is, funds for a regional prevention strategy could be used to support a variety of approaches that are designed by community members in each settlement. If a similar framework was developed in regions such as Nunavik, various program activities could be implemented as community members and workers come forth with suggestions. Other activities recommended in this appendix could also be adapted to form part of a community-based suicide prevention program.

For more information:
Susan Soule, Community-Based Suicide Prevention Program
Rural Services, Division of Alcoholism & Drug Abuse
Alaska Department of Health & Social Services
Box 110607
Juneau, Alaska 99811-0607
(907) 465-3370 (telephone)
(907) 465-2185 (fax)
www.hss.state.ak.us/htmlstuf/alcohol/SUICIDE/SUICIDE.HTM (website)

To order "Close to Home" CD-ROM:
The Alaska Council on Prevention of Alcohol and Drug Abuse
4111 Minnesota Drive
Anchorage, Alaska 99503
(907) 258-6021 (telephone)

Call for prices

A3. Miyupimaatisiiuwin Wellness Curriculum

The Miyupimaatisiiuwin Wellness Curriculum presents a comprehensive school-based approach to health promotion and, by extension, to long-term suicide prevention. It is currently being developed for the Cree Public Health Module in Montreal (Quebec) by SWEN Productions, represented by Barbara Reney, Joan Brackenbury and Janette Barrington, under the direction of Robert Imrie, Health Promotion Officer for the Public Health Module (Cree Region of James Bay). Although still in the final draft stage of production at the time of this writing, this curriculum provides an important example of school-based programming emphasizing Aboriginal culture.

The general features of a suicide prevention strategy, as set out in the guidelines section of this report, are present in the curriculum. Briefly, these include:

1) suicide prevention being taken on as the responsibility of the entire community;
2) a focus on children and young people;
3) a holistic approach reflecting the complex nature of the problem;
4) a comprehensive approach, including long-term approaches and interventions;
5) evaluation viewed as essential;
6) cultural ownership.

The curriculum planning initially involved extensive consultation with the Cree community and included input from the Cree Board of Education. Although the Miyupimaatisiiuwin Wellness Curriculum is original in concept and delivery, its inspiration came from a School Health Program, previously developed and implemented in the Northwest Territories. A description of the NWT School Health Program is included in Appendix B.

The Miyupimaatisiiuwin Wellness Curriculum is comprehensive, covering a wide range of "wellness" issues in a practical, teacher-friendly format, including ready-to-use lessons and preparatory material. It is a preventive program with an emphasis on wellness through health promotion for kindergarten to grade 8. As such, it provides long-term support to children, while the information also reaches parents through a planned parental informed consent component built into each lesson. Relevant issues are extended and developed through the grade levels in a spiral manner, as opposed to isolated presentations, with issues reappearing at each level in more complex form.

The focus is on "wellness," considered by the development team to be an alternative perspective based on issues of self-esteem, positive self-concept development, awareness of peer pressure, values, and abuse prevention. The development team considers these factors to be contributors to the prevention of suicidal behaviours, although there is no specific suicide-related theme in the curriculum.

The Miyupimaatisiiuwin Wellness Curriculum is divided into four sections: *Strong Self, Strong Relations, Strong Body*, and *Strong Future*. The program at the early elementary levels includes *Miyupimaatisiiuwin 4 Kids Activity Book* with Teacher Notes, which complement the language-free, animal-based activity book. Suggestions for delivery of lessons leave room for teachers' own ideas in order to reflect individual and community characteristics, and teachers are encouraged to involve the community in the adaptation of lessons to their students' unique needs and abilities.

The curriculum team was concerned that all students be involved in the learning process, whatever their skills and learning style. Through the incorporation of multiple intelligences theory, they developed "a wide variety of resource materials and opportunities for students to express themselves in a variety of ways and at their own pace" (B. Reney, *personal communication*, August 1998).

Evaluations are consistently included as a part of the classroom lessons. A formal evaluation will need to be considered as an essential component of the Miyupimaatisiiuwin Wellness Curriculum. This could take place in the form of short-term monitoring of a pilot program in cooperation with the Cree Board of Education, as well as long-term follow-up of students in the program from kindergarten to grade 8.

For more information:
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reneyb@colba.net (e-mail)

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A4. Let's Live!

Let's Live! is an example of a school-based awareness and intervention program that meets some of the RCAP (1995) general guidelines for suicide prevention approaches. The student program is taught in grades 8-12 using 5 theme-driven lesson plans. The British Columbia Council for Families, which developed the program in 1992, provides this overview in the inservice guide:

> "The purpose of this Inservice Guide is to provide you with the guidance and support you need to initiate and maintain a suicide awareness and intervention program in your school. It contains information on teaching an inservice workshop to heighten educators' knowledge of the factors contributing to and affecting teenage suicide, and to familiarize school staff with the *LET'S LIVE!* program. It also provides specific direction for dealing with crisis situations" (p. iii).

The program guide covers the inservice workshop and provides the content and procedures for two sessions. Resources and materials, including handouts and a teacher's manual, are followed by theme-based lessons for students, covering the following topics: *What is Suicide?; How Can I Tell if Someone is Suicidal?; Why Do Teenagers Attempt Suicide?; How Can I Help Someone Who is Suicidal?;* and *How Can I Get the Most Out of My Life?*

Designed to educate students about suicide by promoting self-awareness, self-esteem, and a sense of personal power, the problem of teen suicide is acknowledged, and efforts to understand and do something concrete about it are encouraged. The teacher's manual provides advice on creating "a classroom environment that promotes compassion, empathetic listening, and friendship" (p. iii).

The evaluation of this program included pilot testing in the spring of 1992. *Let's Live!* was pilot tested in School District #43 (Coquitlam, B.C.) at four secondary or junior high schools. Inservice training was held for representatives from each school with positive responses from all schools, teachers and students. Materials and lessons were found to be appropriate in the classrooms. During pilot testing, "two students presented themselves to the counsellor's office as being suicidal" (p. iv).

The *Let's Live!* program was evaluated further in 1994 with a mail-out survey to the schools who had ordered the program materials. There was a very poor response rate of 22.5% (72/320). The respondents, from across British Columbia, included school counsellors, teachers, social workers, community health nurses, educational coordinators, students, a consultant to First Nations, a member of a First Nations band, a regional suicide consultant, and clinical counsellors. Forty of the respondents (56%) had received *Let's Live!* training. Many (54%) were interested in the program for school-based program development or professional development. Fifteen respondents (21%) had plans to implement the program during 1994. Twenty-one (29%) had used their *Let's Live!* knowledge and materials in program implementation, 18 (25%) had utilized the assessment or referral skills, and 11 (15%) had delivered the student lesson plans. Successful implementation of the program was attributed to circumstances (e.g. excellent guidance program, successful peer counselling program, forced to look into issue as a result of suicide cases), skills (e.g. highly trained guidance counsellors), processes undergone (e.g. crisis team response, reframing of *Let's Live!*, meeting with community committee, attendance at RCMP-sponsored workshop), or other (e.g. student requests, community networks, high commitment level of those involved in prevention, decision to speak out, and inservice development). B.C. Council for Families has not had the funding to do any further evaluation of *Let's Live!* (C. Haw, *personal communication*, February 1999).

Recently, a one-day workshop on suicide intervention for school personnel (gatekeepers) was developed to replace the inservice training component of the *Let's Live!* program. The workshop was given a new name—*ASK•ASSESS•ACT*—to distinguish it from the student component of *Let's Live!* and to better reflect training goals. Its aim is to improve the overall competency of school personnel in the recognition and crisis management of potentially suicidal youth. *ASK•ASSESS•ACT* was based on the Let's Live! program, input from a focus group of B.C. teachers, a literature search, guidance from a provincial advisory committee, and the 1997 CUPPL (Co-operative University-Provincial Psychiatric Liaison) School Gatekeepers Needs Assessment Survey, University of British Columbia. It consists of 5 hours of training including a lecture, experiential exercises, viewing of a video, large and small group discussion, and simulations.

A formal evaluation of the *ASK•ASSESS•ACT* workshop took place in 1998 in 6 B.C. school districts. The methods included before and after tests of attitudes and knowledge, a participant observation checklist to measure skills, and a participant satisfaction questionnaire, completed by 57 of the 74 participants (77%). Overall, the program appeared to meet its objectives: participants adopted attitudes favourable to intervention, knowledge levels about warning signs and school intervention protocol increased, the necessary skills were gained (e.g. risk assessment), and 100% of respondents would recommend the workshop to their colleagues. An unexpected result of the workshop was that a closer examination or revision of school suicide intervention protocol (or even the development of new protocol) took place in almost all of the schools involved. *ASK•ASSESS•ACT* is also being evaluated in the current fiscal year (C. Haw, *personal communication*, February 1999).

The *Let's Live!* program materials were slightly revised in 1994, following the above evaluation, and can be purchased for $57.08 (including shipping & handling and GST). B.C. Council for Families can provide a quote for the cost of an *ASK•ASSESS•ACT* training workshop. The Council also sells pamphlets on suicide awareness for students, parents, and school personnel based on the *Let's Live!* materials. The results of the literature search are summarized in a 90-page annotated bibliography on *Suicide Prevention and Intervention Training for School Personnel: Program Design and Implementation Issues,* available for $17.65 (including shipping & handling and GST).

For more information:
Cheryl Haw, Director
B.C. Council for Families
204-2590 Granville Street
Vancouver, BC V6H 3H1
(604) 660-0675 (telephone)
(604) 732-4813 (fax)
bccf@istar.ca (e-mail)
www.bccf.bc.ca (website)

To order manual:
Publications Department
B.C. Council for Families
204-2590 Granville Street
Vancouver, BC V6H 3H1
(604) 660-0675 (telephone)
(604) 732-4813 (fax)
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A5. Life Skills Training

The World Health Organization (WHO) has developed a life skills education program for children and adolescents. The goals of a life skills program are to teach skills that individuals need in order to deal effectively with the demands and challenges of everyday life, such as communication, decision-making, self-awareness, and problem-solving skills. The WHO has published a 3-part document that outlines a framework for the development, implementation, and evaluation of life skills program (a "How to" manual). Such programs do not teach skills in isolation, but as part of educational activities that include health information, discussion about major life issues, work on motivation and attitude change, and practical activities to promote a positive school atmosphere.

A variety of examples of health promotion and prevention education programs that involve life skills training (including those aimed at suicide prevention) are described in Part 1 *(The Development and Dissemination of Life Skills Education: An Overview)*. Part 1 also covers guidelines for future life skills education initiatives (based on lessons learnt), strategies for program development (including the use and study of life skills programs as a basis for developing new, culturally-appropriate activities), and provides an annotated list of selected life skills resources. Part 2 *(Guidelines: The Development and Implementation of Life Skills Programs)* describes establishing a life skills support infrastructure, formulating objectives, designing program materials, training life skills educators, pilot testing and evaluation, and implementing and maintaining a life skills program. Sample lessons from various countries are also included. Part 3 *(Training Workshops for the Development and Implementation of Life Skills Education)* is primarily intended to assist the training of those people who will be involved in implementing life skills programs at the regional or national level.

A life skills education program, adapted from the WHO framework, could be used as a prevention strategy for Aboriginal children. The most detailed example of the implementation of this kind of program found in our review was *Skills for the Primary School Child* developed by TACADE, an organization in the United Kingdom (see Appendix B25). It is also possible to adapt life skills education for children who are not in school, for adult education, and as part of a community development project. No results of evaluations of the example programs are provided in the WHO documents. Contact would have to be made with the groups involved in order to find out if evaluations had been completed.

For more information:
Dr. J. Orley, Senior Medical Officer
Division of Mental Health
World Health Organization
1211 Geneva 27
Switzerland
(011-41) 22-791-4160 (fax)

A6. Programme d'entraide par les pairs (Peer Support Program)

For youth in school, we recommend a peer support program based on a model developed in 1991 by Fondation JEVI in Sherbrooke, Quebec. This is a prevention and intervention program aimed at youth in secondary school. The program promotes personal growth, better communication skills, and the support of friends in need. It helps peers to be better listeners, encourages help-seeking from professionals, and raises awareness of the signs of suicidal thoughts. The philosophy behind the program is the implementation (and sustaining) of a support network as a concrete, "community" approach to reducing distress (Guide de Gestion Cahier 1, p. 2). The youth volunteers in the network (ideally, numbering 10-15) learn responsibility and become role models for the younger groups in the school. These volunteers are more accessible to the other students than adult professionals.

The coordinator's guides are user-friendly. They cover the 4 steps to implementation of the program: promoting awareness of suicide and the peer support program among students, school staff and parents; recruitment and selection of candidates; training of the youth support team; and evaluation of the program. The guides describe the implementation process step-by-step, and activities are included for the training of the volunteers.

A volunteer selection process is suggested with a list of qualities required for a good helper. For young persons who are interested in the program but do not meet the selection requirements, suggestions on other ways to integrate them in the program are provided (e.g. being part of a "well-being" committee that organizes a "Well-Being Week," *La semaine du mieux-vivre*, for the school).

Training of the youth helpers is conducted in two sessions of 15 hours of instruction, the first covering knowing oneself and communication skills, the second addressing the helping relationship and adolescent suicide (including how to help a friend in distress, how to intervene in a crisis situation, and how to refer to professional help).

This peer support program resulted from pilot projects in 4 secondary schools between 1985 and 1990. In 1991, the short- and long-term effects of a "Well-Being Week," organized by a committee composed of 12 youths and 8 adults in one of these schools, were studied with a controlled evaluation. A variety of training, group, and communication activities took place during the week (e.g. conferences, personal stories, shows, community breakfast, and social events).

Using before and after validated questionnaires, there were no observed short-term effects on self-esteem, interest in life, social isolation, or depression level, when 159 exposed secondary 3 students were compared to 157 non-exposed students from a different school. In the longer term, 326 current and former students who had experienced the Well-Being Week showed improvement of peer relationships, development of mutual support and listening skills, and greater awareness of the value of life. These findings were

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based on opinions provided by former students and a questionnaire created for the study. The beneficial effects were greater among the older, former students, but these respondents represented only 16% of exposed former students, and there was no control group for this part of the study.

The peer support program is not costly as it is run by youth volunteers and requires only a coordinator to implement and supervise the program, a position that could be assumed by school personnel already in place. The program guides can be purchased for $20 (Cahier 1) and $15 (Cahier 2), not including shipping & handling. Although the guides are available in French only (an English translation is currently in progress), an instructor from Fondation JEVI can provide training for the program in French or English (J. Chagnon, *personal communication*, February 1999).

For more information:
Joyce Chagnon
Fondation JEVI
86 13e avenue Nord
Sherbrooke, QC J1E 2X7
(819) 564-1354 (telephone)
(819) 564-4486 (fax)

A7. Native Parenting Program

For Aboriginal parents, we recommend the Native Parenting Program developed in Saskatoon, Saskatchewan. This is a 12-week course, run twice a year for 15-20 participants, that starts with the *Nobody's Perfect* parenting program (combined with the Native *Kisewatotatowin Parenting Classes*) and is followed by a *Native Cultural Program*. Most of the participants are of Aboriginal ancestry. The goals of the Native Parenting Program are to engage people in speaking about their own experiences, help participants gain a deeper understanding of their emotions and anger, examine Native customs and parenting skills, increase cultural pride and self-esteem, promote recognition of risk factors, and increase knowledge of the resources available and how to access them.

Nobody's Perfect is an education program designed for parents of young children (0-5 years), and has been implemented in 10 provinces and the Northwest Territories (these sites include a number of Native communities). The program uses easy-to-read materials, and relies heavily on group support and adult education techniques to help parents recognize and build on their own strengths. An informal, non-lecture style is used and the program is suitable for parents who have few resources available to them. It is not, however, intended for families in crisis or those with serious problems. The content includes child health and safety, emotional health and behaviour of children, problem solving, and use of 5 core books (at home) that address the body (health and illness), safety, mind (child development), behaviour, and needs of parents. All resource materials are practical, easy to use and can be purchased from Canada Communication Group. This program is also available in French, as *Y'a personne de parfait*.

The *Kisewatotatowin Parenting Classes* are designed to enhance the cultural knowledge of the participants, re-examine and acknowledge Aboriginal teachings and traditional practices, and create a culturally-responsive parent model. The manual was developed from an Aboriginal perspective in 1993 and is available from the Saskatoon Aboriginal Parenting Project. This program is suitable for individuals with a limited educational background.

The Native Parenting Program sessions always open with Native ceremonies such as burning sweet grass and sage and talking circles. The activities offered as part of the *Native Cultural Program* include Native crafts and a food resource class in which nutritious and inexpensive meals are prepared. Participants can also apply for a leadership training course. Various incentives are offered to encourage and enable people to take part; day care and transportation assistance is provided. The Native Parenting Program is fairly inexpensive as it only needs space (e.g. in someone's home or at a community centre), a group facilitator willing to learn the course material (a volunteer, nurse, or community worker), and some volunteers to keep young children occupied or provide transportation. We did not find information about an evaluation of this program, although pilot testing of *Nobody's Perfect* was carried out in Native communities in two provinces.

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For more information:
Louise McKinney, Native Health Worker and Parent Educator
Westside Community Clinic
631 20th Street West
Saskatoon, SK S7M 0X8
(306) 664-4310 (telephone)
(306) 934-2506 (fax)

For more information about Kisewatotatowin Parenting Classes:
SkyBlue Mary Morin
c/o Saskatoon Aboriginal Parenting Project
P.O. Box 8552
Saskatoon, SK S7K 6K6

For more information about Nobody's Perfect:
Fearon Blair
B.C. Council for Families
(250) 372-1873

To order Nobody's Perfect Resource Book for Facilitators:
Emily Franco
B.C. Council for Families
204-2590 Granville Street
Vancouver, BC V6H 3H1
(604) 660-0675
(604) 732-4813
bccf@istar.ca (e-mail)
This resource book can be purchased for $25

To order Nobody's Perfect resource materials:
Canada Communication Group-Publishing
Ottawa, ON K1A 0S9
1-800-561-4334 (telephone)
These materials include an administrative manual, flip chart, leader's guide, parent resource kit, promotional brochures (100), promotional posters (10), training manual, and VHS video.

A8. Family Workshop: Parents and Problems Parenting Program

A second recommended parenting program is aimed at parents and their adolescents. The Family Workshop: Parents and Problems Parenting Program, developed in the U.S., has been implemented in the First Nations community of Big Cove, New Brunswick. Each of the 7 sessions of the program are carefully designed to foster discussion and interaction among the adults and their adolescent children. The goals are to enable parents to better understand their own behaviour towards each other and their adolescent(s), how adolescents perceive the behaviour of their parents, and what makes adolescents behave as they do. In this way, the program aims to prevent mental health problems, drug and alcohol abuse, and criminal activity among adolescents. Both the parent(s) and the adolescent(s) should participate in the workshops.

The number of participants varies from 9-14 (that is, a maximum of 3 or 4 families). The workshop leaders need not be therapists nor experts in family dynamics, but concerned community members willing to be trained how to facilitate the sessions. This training takes place in Big Cove, with follow-up telephone and fax contact. It is preferable to involve two facilitators in the sessions. The group meets weekly to cover the following topics: *Through the Eyes of Youth; Do Adults Understand Me?; Do My Parents Love Me?; But They're My Friends; Adolescent Sexuality;* and *Why Can't I Do It My Way?* The last session, I Don't Have Two Parents, addresses the unique issues of single parenting and an adolescent's behavior in this context.

The sessions (about 3 hours in length) generally start with a discussion of the previous week, a review of the new session material, and then group discussion and exercises. Reading materials (at the junior high school level) are distributed for the following session. The program materials include a leader's manual, 7 Parents and Problems pamphlets for each family, and exercise materials for each participant. We did not find information about an evaluation of this program.

For more information:
Harry Sock, Director
Child and Family Services
Big Cove Indian Band, Site 11, Box 1
Big Cove, NB E0A 2L0

A9. Multimedia CD-ROM: Mauve

As an additional support, we recommend the Mauve CD-ROM produced by Médiaspaul and Pentafolio Inc., with the participation of Health Canada, for young people aged 12-18 years. This interactive tool, available in English or French, aims to help foster independent thinking and encourage dialogue. Released in 1998, English- and French-speaking teenagers participated in the research, development and production; excerpts of their statements are used to present problems and solutions. The goals are to help teenagers with problems open up, reduce feelings of isolation by presenting viewpoints from teenagers facing similar difficulties, and help youth identify self-destructive patterns, view problems more objectively, and gain a sense of life's deeper meaning. In this way, the tool aims to promote positive attitudes regarding the topics covered (e.g. love, sex, work, school, family, society, life and self-image), create general health awareness, promote mental health and prevent depression, drug abuse and suicide. The CD-ROM can also be used to help adults and parents understand young people better.

The content format includes personal accounts, video clips, animation, sound effects, music, writings, photographs, and illustrations. Working with the CD-ROM is very interactive (navigation through the themes is controlled by the user) and can be made quite private. Statements on depression and suicide are only reached after the user passes through various levels of negative statements, which serves to select users in a similar state of mind; the content is then geared towards breaking a sense of isolation and encouraging expression of feelings and help-seeking. In order to leave the suicide section of the CD-ROM, the user must pass through a series of positive, life-affirming statements.

The Mauve CD-ROM can be used prior to counselling or as a complement to guidance sessions. A resource guide for health professionals will supplement the tool. The CD-ROM has been extensively tested by teenagers, who have given it enthusiastic approval, and has been endorsed by several Canadian mental health professionals. Médiaspaul and Pentafolio are establishing guidelines for its adaptation to other countries and cultures. There is little or no specific Aboriginal content, but it may still prove useful, although not ideal, for Aboriginal youth. A formal, independent evaluation has not yet been completed but is planned for the near future.

To use the CD-ROM, the resources required are either a PC (Windows 95, Pentium 133 [min. 90 MHz], 16 MB of RAM [min. 8], CD player 8x [min. 4x], 16-bit sound card, High Colour setting on monitor, Quicktime 2.1 [included]) or Power Mac computer (16 MB of RAM, CD player 8x [min. 4x]). The Mauve CD-ROM is sold for $140 (plus $3.50 shipping and handling) in a resource kit that includes a teen support guidebook, navigational map, and access to an Internet discussion group.

For more information:

Médiaspaul Inc.
3965 boul. Henri-Bourassa Est
Montréal-Nord, QC H1H 1L1
(514) 322-7341 (telephone)
(514) 322-4281 (fax)
mediaspaul@mediaspaul.qc.ca (e-mail)

Pentafolio Multimedia
1277 Pilon Road
Clarence Creek, ON K0A 1N0
(613) 488-3921 (telephone)
(613) 488-3922 (fax)
mauve@pentafolio.com (e-mail)

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Appendix B. Description of Programs Reviewed

The descriptions of the programs in this appendix are reproduced from the original sources. Some follow-up contact was made to obtain more details. Costs quoted are those at the time of publication of the resources, and may differ from current prices. Several suicide prevention manuals, pamphlets and other materials were included in the review, and are listed at the end of the appendix.

Table B1 on the next page summarizes some of the key features of the programs reviewed. Programs are categorized as to their focus (i.e., suicide in particular, mental health in general, or both), target group(s), Aboriginal content, and whether they were evaluated.

The type of evaluation carried out for each program was determined on the basis of available information and was left blank if we did not find any indication of an evaluation. The following evaluation types were used:

- *Anecdotal* evidence refers to non-systematic gathering of impressions of a program (e.g. comments by those involved in a pilot test).
- *Systematic qualitative* or *systematic quantitative* evaluations involve a formal study in which data on outcomes are collected (e.g. open-ended, qualitative interviews of participants, a quantitative survey of rates or frequencies before and after an intervention).
- A *controlled* evaluation is one in which a region or population that was exposed to a program was compared to a control region or population that did not participate in the program. This is the most rigorous form of evaluation represented.

The descriptions of the Quebec school-based programs in this appendix are presented in French; all other descriptions are in English to match the language of the program materials.

Table B1. Summary Table for Programs Reviewed

	FOCUS		TARGET GROUP							EVAL. TYPE	ABORIGINAL CONTENT	
Program #	Specifically suicide	General mental health	Entire community	Children	Adolescents	Adults	Elders	Women / Girls	Caregivers / School staff	*See below for codes	Produced by Aboriginals	Adapted for Aboriginals
1										A		
2										A		
3										QL		
4										QN		
5												
6										QN		
7												
8										A		
9										C		
10										QN		
11												
12										A		
13												
14												
15												
16										A		
17										QN		
18												
19										C		
20												
21										QL		
22										C. QN		
23												
24										A		
25												
26										QN		
27										A		
28												
29										A		

*Type of evaluation (if any). A=anecdotal; QL=systematic qualitative; QN=systematic quantitative; C=controlled

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B1. Adolescent Suicide Awareness Program (ASAP)

This is a school-based suicide awareness program, developed in New Jersey, that has served as a model for other regions including Canada. Educators and school personnel receive a 3-hour intensive seminar, students attend a 4- to 6-hour workshop, and the parents' program can vary from a 30-minute overview to a 2-hour seminar. Its goals are to disseminate information about the recognition and prevention of adolescent emotional difficulties and suicidal behaviour to all members of the school community, and promote help-seeking behaviours. Content includes warning signs, causes, and facts about adolescent suicide, how to help in a crisis, depression in adolescents, and availability of community professional services. Resources required are the training of local mental health professionals to deliver the program; these persons can later train school personnel to carry out the workshops themselves. A rating scale is suggested for an evaluation after each workshop. Anecdotal information about its impact on the school system is positive, showing an increase in mental health provider referrals, improved communication, more trust between students and school staff, and improved identification of students at risk. Longer term, in-depth evaluation of this program is needed.

For more information:
Diane Ryerson
Peake/Ryerson Consulting Group Inc.
Englewood, NJ
compcare@carroll.com (e-mail)
http://www.compcare.org/ (website)

B2. Cherish the Children

This program, used by the Minnesota Indian Women's Resource Center, was specifically designed in 1988 for young Native parents with infants and preschoolers, but is helpful for Aboriginal parents with children of any age. The program consists of 14 weekly lessons including learning objectives, lecture and work sheets, a description of parent-child activities, evaluation suggestions and a list of readings. Each session (of 45-60 minutes) involves small and large group activities, sharing and reading stories. The curriculum is written at a grade 3 reading level and is appropriate for single and 2-parent households. The content includes talking and listening skills, health and safety issues, traditional foods, self-esteem, learning through play, and language, social and emotional development. The goals are to help parents adapt to rapid social change, understand traditional beliefs and methods of parenting, and to help hold the family circle sacred. Resources required are a program package and a facilitator familiar with the course material. The package containing a trainer's manual and 5 participant manuals can be purchased for $50 (U.S.; English only). Excellent feedback was received for this program during early field testing. The Minnesota Indian Women's Resource Center is planning to revise the program in order to expand the section on discipline.

For more information:
Renee Lampi
Minnesota Indian Women's Resource Center
2300 15th Avenue South
Minneapolis, Minnesota 55404
(612) 728-2009 (telephone)
(612) 728-2039 (fax)

B3. Child and Family Resource Centre

This program, operating in Cranberry, Manitoba, involves varied and intersectoral activities including: a community kitchen, a family literacy program, an Aboriginal culture component teaching children Cree story-telling and crafts, a lending library (for books, toys), a monthly newsletter written by parents and distributed to the community, and resources and parenting courses for high risk parents. The goals are to support/empower children (0-6 years old), provide services for pregnant women at risk, promote healthy living and parenting, and create supportive environments for mutual aid and learning. Resources required are a community worker or professional to give parenting courses and a supervisory board. An evaluation was carried out by interviewing staff and participants, attending board meetings and reviewing the strategic plans (no other information available). Parents provide ongoing feedback.

For more information:
Wendy Trylinski, Program Coordinator
Child and Family Resource Centre
Box 212
Cranberry Portage, MB R0B 0H0
(204) 472-3671 (telephone)
(204) 472-3714 (fax)
childfam@mb.sympatico.ca (e-mail)

B4. Community-Based Suicide Prevention Program (see also: Appendix A2)

The Community-Based Suicide Prevention Program (CBSPP) has been developed and implemented by Alaska Native communities. The program is state-funded and provides grants to support community-based suicide prevention activities; 48 communities received grants in 1988 and this number increased to 66 by 1995. These activities target different areas of the prevention spectrum, ranging from mental health promotion to suicide intervention and postvention. The basis of the CBSPP is a "grass-roots" strategy which involves the whole community, incorporates cultural values, encourages traditional activities, and takes a holistic approach to wellness. A user-friendly coordinators' handbook was produced in 1996 by CBSPP coordinators responsible for overseeing community activities. The coordinators from different communities have also developed an important network to support one another. They share vital information through a newsletter and hold conferences. Most communities have incorporated one or more of the following activity types in their program: (1) youth/elder communication (e.g. cultural instruction, support groups for youth or elders or both); (2) cultural projects (e.g. crafts, kayak building); (3) volunteer helping systems; (4) recreational activities (e.g. camping, kid's night, family night); (5) counselling; (6) crisis response; and (7) education/prevention. An interactive training CD-ROM entitled "Close To Home: Suicide Intervention in Rural Alaska" has been produced in collaboration with Yupiit Eskimo people (for call for prices). Resources required are regional funding, local planning committees, and community coordinators; the CD-ROM requires a Macintosh or IBM-compatible computer with a CD-ROM drive. The CBSPP program was independently evaluated from 1989 through the spring of 1993. At the end of three years, rates in project communities declined faster than state-wide Alaska Native rates; in the five project communities studied in depth, there was an increase in the number of people who knew warning signs of suicide, and who knew how to refer an at-risk person. A Participatory Prevention Program Evaluation Project is currently underway.

For more information:
Susan Soule, Community-Based Suicide Prevention Program
Rural Services, Division of Alcoholism & Drug Abuse
Alaska Department of Health & Social Services
Box 110607
Juneau, Alaska 99811-0607
(907) 465-3370 (telephone)
(907) 465-2185 (fax)
www.hss.state.ak.us/htmlstuf/alcohol/SUICIDE/SUICIDE.HTM (website)

To order "Close to Home" CD-ROM:
The Alaska Council on Prevention of Alcohol and Drug Abuse
4111 Minnesota Drive
Anchorage, Alaska 99503
(907) 258-6021 (telephone)

B5. Family Workshops: Parents and Problems (see also: Appendix A8)

This program, developed in the U.S., has been implemented in the First Nations community of Big Cove, New Brunswick. Each of the 7 sessions of the program are carefully designed to foster discussion and interaction among the adults and their adolescent children. The goals are to enable parents to better understand their own behaviour towards each other and their adolescent(s), how adolescents perceive the behaviour of their parents, and what makes adolescents behave as they do. In this way, the program aims to prevent mental health problems, drug and alcohol abuse, and criminal activity among adolescents. Both the parent(s) and the adolescent(s) should participate in the workshops. The number of participants varies from 9-14 (i.e., a maximum of 3 or 4 families). The workshop leaders should be concerned community members willing to be trained how to facilitate the sessions. This training takes place in Big Cove, with follow-up telephone and fax contact. It is preferable to involve two facilitators in the sessions. The last session, *I Don't Have Two Parents*, addresses the unique issues of single parenting and an adolescent's behavior in this context. The sessions (about 3 hours in length) generally start with a discussion of the previous week, a review of the new session material, and then group discussion and exercises. Reading materials (at the junior high school level) are distributed for the following session. Resources required are the program materials (leader's manual, 7 Parents and Problems pamphlets for each family, and exercise materials for each participant), one or two community members willing to be trained as facilitators, and the costs of training in Big Cove. We did not find information about an evaluation of this program.

For more information:
Harry Sock, Director
Child and Family Services
Big Cove Indian Band, Site 11, Box 1
Big Cove, NB E0A 2L0

B6. Jicarilla Mental Health & Social Services Program (see also: Appendix A1)

This multifaceted prevention and intervention program, which began in a New Mexico Native community in January 1990, includes providing mental health and social services that were previously unavailable in the community and implementation of the CDC guidelines for containing suicide clusters. The program uses a community-based, family-centred approach to suicide prevention, and emphasizes cultural values and traditions. The following components are supported: (1) school-based "natural helpers" involving 10-25 youth each year who are trained to respond to young people in crisis, notify mental health professionals when they need assistance, and provide school and community education on alcohol and drug prevention, self-esteem and team building, and suicide prevention; (2) outreach to families after a suicide or traumatic death/injury (3) immediate response and follow-up for youth reported to be at risk; (4) community education about suicide prevention, domestic violence, child abuse, economics, sexuality, substance abuse, and parenting; and (5) training of teachers, school personnel, peer counsellors, emergency transportation staff and police in suicide risk assessment, and suicide risk screening in mental health and social service programs. Resources required are youth volunteers, training of natural helpers and community workers, mobilization of health and social service resources, and a central coordinating team. Rates of suicidal acts among young persons 15-19 years old substantially decreased almost immediately after the implementation of the program, and this improvement was sustained over the following 5 years. Further evaluation of this program will be important, and should include a comparison of rates of suicidal acts within other tribal communities in New Mexico without such a program.

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For more information:
Pat Serna, Director
Jicarilla Mental Health & Social Services
P.O. Box 546
Dulce, New Mexico 87528
(505) 759-3162 (telephone)
(505) 759-3588 (fax)
cspcn@cvn.com (e-mail)

Debra Hurt, Coordinator
American Indian/Alaska Native Community Suicide Prevention Centre & Network (AI/AN CSPCN)
P.O. Box 546
Dulce, New Mexico 87528
(505) 759-3162 (telephone)
(505) 759-3588 (fax)
cspcn@cvn.com (e-mail)
www.jade2.tec.nm.us/cspcn/cspcnfrm.htm (website)

B7. Kishawehotesewin: A Native Parenting Approach

This 7-session program developed by Jocelyne Bruyere in 1993 (Nee-Nah-Win Project) has been used in Alberta for First Nations parents and expecting parents, and conforms with the 7 Traditional Native teachings. The sessions can be presented weekly or as a 3-day workshop. Activities include sharing in a circle, readings, videos, role playing, discussion and assignments. The program assists and supports parents in identifying and realizing their goals, helps them listen to their children, encourages them to share their knowledge about Native traditions, provides general information on resources, allows parents to reappraise their parenting styles and situations, and provides culturally-relevant materials. Resources required are a trained facilitator. The manual can be purchased for $6.50 (English only). The materials have been presented in Native languages with the use of a translator. We did not find information about an evaluation.

To order manual:
Human Resource Centre, CPHA
1565 Carling Avenue, Suite 400
Ottawa, ON K1Z 8R1
(613) 725-3769 (telephone)
(613) 725-9826 (fax)

B8. La prévention du suicide auprès des jeunes en milieu scolaire (School-based Suicide Prevention for Youth)

This program framework, developed in Quebec in 1994 and aimed at high school students, promotes a broad approach to suicide prevention that includes health promotion, prevention, crisis intervention and postvention. Its goals are to raise awareness of the problem, help youth recognize signs of distress in their peers, facilitate communication between parents and their children, increase conflict- and problem-resolution skills, and create a favourable environment for exchange between students and school personnel. Suggested program activities include the use of videos, a newsletter, theatre, games, workshops, a "well-being" week, pamphlets to raise awareness of the problem, formation of a natural helpers team, and development of intervention and postvention protocols. Resources required are training of intervenors, the program framework document (available for $5; French only), a prevention committee and collaboration with a suicide prevention centre. This program was implemented in two schools in 1994-95. Preliminary results of an organizational evaluation suggest that the successful implementation of this program requires the need for it to be expressed from within the school and the involvement of all teaching and direction staff.

For more information:
Centre de prévention du suicide de la Haute-Yamaska Inc.
436 rue Horner
Granby, QC J2G 3T5
(450) 375-4252 (telephone)
(450) 375-5319 (fax)

B9. La prévention du suicide en milieu scolaire secondaire: Une approche communautaire (Community Approach to Suicide Prevention)

This secondary school-based program framework was developed by Suicide-Action Montreal in 1985. The goals are to inform teens and support their role as prevention agents (encouraging the implementation of a peer support group), inform parents, teachers, administrators and other school workers about adolescent suicide, problems faced by youth and the role they can play in preventing suicide, provide tools to professionals to help them intervene more effectively, promote collaboration between the above groups, and ensure that appropriate resources are accessible in the school. Several training sessions, pamphlets, posters and videos are used in the program. Resources required are a program coordinator, the framework document (available for $7.50; English or French) and collaboration with a suicide prevention centre or other competent organization/ professional. A 1987-88 controlled evaluation of a program following this model in Laval and St-Jerome CEGEPs (1110 students exposed) found that knowledge of student services improved for the experimental group (n=147), while knowledge of suicide warning signs and awareness did not. Fifteen suicidal youths presented themselves for help. The results raised questions about the effectiveness of one-time awareness programs of brief duration. A new program is currently under development and will be available by fall 1999.

For more information:
Yannick Arsenault
Suicide-Action Montréal Inc.
C.P. 310, succ. St-Michel
Montréal, QC H2A 3M1
(514) 723-3594 (telephone)
(514) 723-3605 (fax)

B10. Let's Live (see also: Appendix A4)

Let's Live! is a school-based awareness and intervention program that was developed by the British Columbia Council for Families in 1992. Designed to educate students about suicide by promoting self-awareness, self-esteem, and a sense of personal power, the problem of teen suicide is acknowledged, and efforts to understand and do something concrete about it are encouraged. Program materials, including handouts and a teacher's manual, are followed by 5 theme-based lessons for students. The inservice workshop component was designed to educate school personnel. Resources required are the program manual (available for $57.08). Pilot testing of *Let's Live!* was favourable and resulted in two suicidal students presenting themselves at the counsellor's office for help. A 1994 survey of schools who ordered the *Let's Live!* materials had a poor response rate and does not provide details on the impact of the program on students. A recently revised inservice workshop, with the new name of *ASK•ASSESS•ACT*, provides school personnel with 5 hours of suicide intervention training. B.C. Councils for Families can provide a quote for the cost of providing this workshop. *ASK•ASSESS•ACT* was successful in meeting its goals in a 1998 evaluation in 6 B.C. school districts.

For more information:
Cheryl Haw, Director
B.C. Council for Families
204-2590 Granville Street
Vancouver, BC V6H 3H1
(604) 660-0675 (telephone)
(604) 732-4813 (fax)
bccf@istar.ca (e-mail)

To order manual:
Publications Department
B.C. Council for Families
204-2590 Granville Street
Vancouver, BC V6H 3H1
(604) 660-0675 (telephone)
(604) 732-4813 (fax)
bccf@istar.ca (e-mail)

B11. Life Skills Education for Children and Adolescents in Schools (see also: Appendix A5)

This is a 3-part document published by the World Health Organization (WHO) that outlines a framework for the development, implementation, and evaluation of school-based Life Skills programs for children and adolescents. The WHO model could also be adapted for use with young people who are not in school or adults. The goal of such a program is to enable the participant to deal effectively with the demands and challenges of everyday life. The document gives examples of health promotion and prevention education programs that involve life skills training. Resources required are a teacher or community worker trained in Life Skills Education or willing to be trained. The references for the three parts of this document are: MNH/PSF/94.7, WHO/MNH/PSF/93.7A Rev 1, and WHO/MNH/PSF/93.7B Rev. 1 (English only; available from WHO). No results of evaluations of the example programs are provided in the WHO documents.

For more information:
Dr. J. Orley, Senior Medical Officer
Division of Mental Health
World Health Organization
1211 Geneva 27
Switzerland
(011-41) 22-791-4160 (fax)

B12. Mauve CD-ROM (see also: Appendix A9)

This is an interactive CD-ROM, available in English or French, that was released in Canada in 1998 for teens 12-18 years old. Adolescents were involved in all aspects of production. The goals are to promote communication, positive attitudes, general health awareness, and mental health. Resources required are either a PC (Windows 95, Pentium 133, 16 MB of RAM, CD player, 16-bit sound card) or Power Mac computer (16 MB of RAM, CD player). The CD-ROM is sold for $140 (plus $3.50 shipping and handling). Formal evaluation of the CD-ROM is currently being planned.

For more information:
Médiaspaul Inc.
3965 boul. Henri-Bourassa Est
Montréal-Nord, QC H1H 1L1
(514) 322-7341 (telephone)
(514) 322-4281 (fax)
mediaspaul@mediaspaul.qc.ca (e-mail)

Pentafolio Multimedia
1277 Pilon Road
Clarence Creek, ON K0A 1N0
(613) 488-3921 (telephone)
(613) 488-3922 (fax)
mauve@pentafolio.com (e-mail)

B13. Mental Health Education

This is a program framework developed by WHO to promote mental health and prevent and treat mental health problems within the school system. The goals of the program are to provide information about mental health and illness, destigmatize illness, and help clarify students' attitudes and behaviour regarding mental health. Resources required are a program coordinator and training of teachers. The reference for the document describing this framework is: Mental Health Programmes in Schools, WHO/MNH/PSF/93.3 Rev. 1 (English only). The document gives examples of mental health education programs in various areas in the world.

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For more information:
Division of Mental Health
World Health Organization
1211 Geneva 27
Switzerland

B14. Miyupimaatisiiuwin Wellness Curriculum (see also: Appendix A3)

The Miyupimaatisiiuwin Wellness Curriculum presents a comprehensive school-based approach to health promotion for kindergarten to grade 8. It is currently being developed for the Cree Public Health Module in Montreal by SWEN Productions. The curriculum planning initially involved extensive consultation with the Quebec Cree community and included input from the Cree Board of Education. Although the Miyupimaatisiiuwin Wellness Curriculum is original in concept and delivery, its inspiration came from the NWT School Health Program. The Miyupimaatisiiuwin Wellness Curriculum covers a wide range of "wellness" issues in a practical, teacher-friendly format, including ready-to-use lessons and preparatory material. The focus is on "wellness," based on issues of self-esteem, positive self-concept development, awareness of peer pressure, values, and abuse prevention. The information also reaches parents through a planned parental informed consent component built into each lesson. Resources required are teacher training with the curriculum. This curriculum is still under development, and formal evaluation of its short- and long-term effects needs to be planned.

For more information:
Barbara Reney
SWEN Productions
3622 rue De Bullion #2
Montreal, QC H2X 3A3
(514) 849-8478 (telephone)
(514) 849-2580 (fax)
reneyb@colba.net (e-mail)

B15. Native Parenting Program (see also: Appendix A7)

This parenting and Native cultural program runs twice a year for 12 weeks with 15-20 participants at the Westside Community Clinic in Saskatoon, Saskatchewan. For the parenting component, a previously developed program called Nobody's Perfect is combined with the Native Kisewatotatowin Parenting Classes for Aboriginal parents and future parents. The cultural programs include Native crafts and a food resource class, and sessions always open with Native ceremonies. The goals are to engage people in talking about their experiences, help participants gain a deeper understanding of their emotions, promote recognition of risk factors, and increase knowledge of resources available and how to access them, and examine Native customs and parenting skills. The participants learn about child health and safety and problem-solving as a way to understand and handle a child's behaviour, receive 5 information books, and participate in group discussions, mutual support and information sharing. Resources required are a group facilitator and child care facilities. Various materials are available for purchase with respect to the Nobody's Perfect program and the Kisewatotatowin Parenting Classes; see appendix A7 for contact information. We did not find information about an evaluation.

For more information:
Louise McKinney, Native Health Worker and Parent Educator
Westside Community Clinic
631 20th Street West
Saskatoon, SK S7M 0X8
(306) 664-4310 (telephone)
(306) 934-2506 (fax)

B16. Ngwaaganan Gamig Recovery Centre (Rainbow Lodge) and Nadmadwin Mental Health Clinic

These programs, which began in the mid-1970s on the Wikwemikong Reserve, focus on youth but involve the whole community, incorporating prevention, public education, treatment, rehabilitation and staff training. Rainbow Lodge is a non-medical alcohol and drug treatment and prevention facility while the Clinic (formerly Wikwemikong Counselling Program) is a mental health support service. The programs attempt to creatively apply holistic healing ideas in order to improve the health of the community, strengthen community self-respect, personal self-esteem, and the Aboriginal family, and help people understand and better respond to suicidal behaviour. Resources required are trained staff, trained volunteers (very important), and a facility. Twenty years later, community members are more likely to refer family and friends with problems to Nadmadwin and seek help themselves.

For more information:
Nadmadwin Clinic
P.O. Box 101
Wikwemikong, ON P0P 2J0
This program was described in RCAP, 1995 (p. 44); in 1994, the director was Alphonse Shawana and the manager was Daniel Manitowabi.

B17. Northwest Territories School Health Program

This 7-unit school education program was developed in the NWT in the late 1980s for kindergarten to grade 9 students. It is a required curriculum that is user-friendly and all-inclusive. Its goal is to prevent or reduce health problems by encouraging individuals to be responsible for their health, facilitate the development of skills and positive attitudes, and create a supportive environment in the schools. The recommended time allocation is 60 hours per

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year and the content includes family life, alcohol and other drugs, nutrition, safety/first aid, dental health, growth/development, and mental and emotional well-being (as the central unit). The lessons involve objectives, teacher background information, student activities, and teacher notes, and incorporate small group discussion, brain-storming, role playing, and a "question box." Resources required are teacher training with the curriculum. A territory-wide teacher survey was carried out in 1991 to find out the extent to which the program was being used and whether the teachers were getting help from others to deliver it (e.g., nurses, elders). High rate of use of the program was reported and about 40% of teachers were using others for the more sensitive topics such as mental health and family issues. A new survey is being considered.

For more information:
Barbara Hall
Department of Education, Culture and Employment
Government of the Northwest Territories
Box 1350
Yellowknife, NWT X1A 2L9
(867) 873-7678 (telephone)
(867) 873-0109 (fax)
barbara_hall@ece.learnnet.nt.ca (e-mail)

B18. Parenting Education Program

This is a program framework promoted by WHO to provide comprehensive parenting education and targeted interventions for the student and young adult population. Its goals are to educate pregnant students, young persons with a high likelihood of early pregnancy, and young parents about child development, discipline, tolerance of misbehaviour, and respect for a child's individuality. Resources required are trained teachers and possibly an association with a daycare or nursery school where youth could volunteer to work with young children. The reference for a description of examples of such programs is: Learning to be Parents: An Annotated Bibliography of Programmes for Young People, WHO/MNH/PRO/88.1.

For more information:
Division of Mental Health
World Health Organization
1211 Geneva 27
Switzerland

B19. Plein le dos: Programme de prévention du suicide en milieu scolaire primaire (Elementary School Suicide Prevention Program)

This is a dynamic and interactive program developed in Quebec in 1993 for children in grades 4, 5 and 6 and involves 2 consecutive 45-minute sessions. Sadness is presented in a monologue by a child character called "Plein le dos," played by a group animator, who suggests that he/she may suicide in order to join his/her grandfather; children identify the stress factors for the character with labelled rocks and solutions written on feathers. The children's sources of pleasure are identified, a suicide prevention "first aid kit" is built, and a visualization exercise is carried out to relaxation music. The goals are to inform children about sadness and what causes it, help them recognize and listen to stress factors of their own and of their peers, develop their communication and problem/conflict resolution skills, and inform them of available resources including confidantes. The children can write to "Plein le dos" during the year and get a response, to allow children to express and share their views, help them with their problems, and facilitate detection of children at risk. Parents and school personnel attend information sessions prior to the child's program. Resources required are two group facilitators, a knapsack and rocks, a lunch bag and feathers, crayons, relaxation tape, tape recorder, and the program kit (including 3 animation guides, a pamphlet for children, a suicide prevention "first aid kit," and available for $40; French only). A controlled evaluation found that the goals were not reached when data for all participants were combined, but there were positive outcomes for children who had thought about suicide. Children in the experimental group learned more about resources than those in the control group. It may be important to adapt the monologue to make it more positive and ensure that suicide is not viewed as a solution by the young audience.

For more information:
Centre Ressources Interventions Suicide du KRTB
26 rue Joly, C.P. 353
Rivière-du-Loup, QC G5R 3Y9
(418) 862-9658 (telephone)

B20. Prévention et promotion du mieux-être (Prevention and Promotion of Well-Being)

This Quebec program framework from 1995 uses an integrated model of prevention that considers secondary school as a micro-society and incorporates health promotion, prevention, intervention and postvention activities. It is suggested that all school personnel be informed about and sensitive to crisis intervention and the prevention of different youth problems. The formation of both a crisis committee and a prevention committee, made up of school personnel and parents, is encouraged. The goals of the program are to educate and support the school system, create and implement activities that promote well-being, train and support natural helpers, increase knowledge of available resources in the school and community, and pass on values related to prevention in daily life. Resources required are training for community workers and association with a suicide prevention centre (a French document about the program is available). Although an evaluation process is encouraged in the program framework, we did not find information about results of any prior evaluations.

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For more information:
Julie Campbell
Le Centre d'Intervention le Faubourg
C.P. 1
St-Jerome, QC J7Z 5T7
(450) 569-0101 (telephone)
(450) 565-2770 (fax)

B21. Program to Enhance Self-concept in Young Children

This program was implemented in three schools in Australia as part of a study to evaluate the feasibility and acceptance of self-concept enhancement in children (5-10 years old) as a means to prevent teenage suicide. The major component of the program is the use of guided imagery, positive self-talk, and creative visualization to enhance self-concept and self-esteem. Resources required are training for teachers or community workers. An evaluation found that the program was both feasible to implement and acceptable to young children, their parents, and teachers. However, it was suggested that acceptability may vary due to cultural differences.

For more information:
Judith Lissing
7 Bridges Street
Maroubra, NSW
Australia 2035
(011-61) 02 9349 8061 (telephone/fax)

B22. Programme d'entraide par les pairs (Peer Support Program; see also: Appendix A6)

This prevention and intervention program aimed at youth in secondary school was developed in 1991 by Fondation JEVI in Sherbrooke, Quebec. It promotes personal growth, better communication skills, and the support of friends in need; helps peers to be better listeners, encourages help-seeking from professionals; and raises awareness of the signs of suicide. The coordinator's guides cover the 4 steps to implementation of the program, including how to select 10-15 youth volunteers. For youth who are interested in the program but do not meet the selection requirements, other ways to integrate them are suggested (e.g. involve them in the organization of a "Well-Being Week"). The youth training is conducted in two sessions of 15 hours of instruction. Resources required are student volunteers, a coordinator to implement and supervise the program, and the program guides (available for $20 and $15, not including shipping & handling; French only, although program training can be provided by JEVI in French or English). In 1991, the short- and long-term effects of a multi-activity "Well-Being Week" were evaluated. While there were no observed short-term effects on self-esteem, interest in life, social isolation, or depression level (comparing exposed and non-exposed students), current and former students who had experienced the Week showed, in the longer term, improvement of peer relationships, development of mutual support and listening skills, and greater awareness of the value of life. The beneficial effects were greater among the older, former students but their response rate was only 16%, and there was no control group for this part of the study.

For more information:
Joyce Chagnon
Fondation JEVI
86 13e avenue Nord
Sherbrooke, QC J1E 2X7
(819) 564-1354 (telephone)
(819) 564-4486 (fax)

B23. Rescousse: Groupe d'entraide (Rescue)

This school-based peer support program, produced in Quebec in 1989 for youth 12-16 years old, encourages promotion, prevention and intervention activities but focuses on the primary prevention aspects. Many approaches are suggested, including sensitization (of students, school staff and parents), rapid and accessible consultation, personnel competence (giving teens tools to handle problems and develop social abilities), and modification of the school environment. The goals of the program are to help youth cope with difficulties and manage stress, and enhance their quality of life. A reference document describes how to create the peer support group, other program activities, and the different stages of development of suicide prevention in a secondary school. Resources required are a program coordinator and teenage volunteers. We did not find information about an evaluation.

For more information:
Gervaise Gagné
Ecole Paul-Hebert
250 boul. Arthur-Buies Ouest
Rimouski, QC G5L 7A7
(418) 724-3439 (telephone)
(418) 724-3471 (fax)

B24. Seniors Group

This program, operating at the Portage Friendship Centre, Portage la Prairie, Manitoba, has Elders working with children (0-5 years old) on a weekly basis to pass on language skills, teachings, and legends. The goals are to restore the self-esteem and self-confidence of Elders, teach the children about their culture and identity, and build cultural pride. Outcomes of the project have been a book profiling the Elders and a colouring book of the stories and legends. Resources required are a program coordinator and Elder volunteers. Observations from the centre show that the program has been very successful for the children and the Elders.

For more information:
Garda Sinclair Moran, Executive Director
Portage Friendship Centre
20 3rd Street NW
Portage la Prairie, MB R1N 1N4
(204) 239-6333 (telephone)
(204) 239-6634 (fax)
portagfc@portage.net (e-mail)

B25. Skills for the Primary School Child (SPSC)

This 1990 program, aimed at primary school children 5-11 years old, has been developed in the United Kingdom. Its goals are to provide opportunities for children to explore relationships, express and share fears and feelings, and build their own and others' self esteem. The content starts by addressing issues and skills relevant to each child and then moves on to look at children as part of the family, school and wider community. The skills taught include communication, assertiveness, decision-making, critical thinking, problem solving, interpersonal relationships, discernment, working with others, dealing constructively with emotions, and ways of resisting peer pressure. The program package contains an educator's manual, materials for 10 workshops for teachers, health workers, other school staff and community members, materials for 6 parent workshops, and 33 complete lessons for children, offering classroom activities and strategies for learning and developing skills. Resources required are the SPSC program package (available for £49.95) and training for teachers or community workers in life skills facilitation (or the hiring of a Life Skills educator who could then transfer skills within a community). We did not find information about an evaluation.

For more information:
Jeff Lee or Vivienne Evans, TACADE
1 Hulme Place
The Crescent
Salford, Greater Manchester
United Kingdom M5 4QA

B26. Sparrow Lake Alliance

Founded in 1989, the Sparrow Lake Alliance is a voluntary coalition of Ontario professionals who work with children (social workers, psychiatrists, psychologists, teachers, etc.), government representatives, and a number of multidisciplinary groups committed to improving the lives of children and their families. The Alliance promotes an increased emphasis on prevention and early intervention in order to improve the physical health, safety, emotional well-being and optimal development of all children in Ontario. The activities of the Alliance include prevention (Ryerson Outreach Program, Helping Children Adjust program), advocacy, and increasing the effectiveness of existing treatment and child welfare services (e.g. psychiatric emergency services, consultation and legal services, collaborative work between mental health professionals and educators). The Ryerson program operates in a disadvantaged inner city area in Toronto, and involves mental health professionals working with school staff. Surveys on teachers' opinions in 1993 and 1995 show that conduct problems and absenteeism decreased, respect shown to others increased, and identification of students with special needs occurred earlier over the two years. Resources required are a professional or para-professional to coordinate the program. The Helping Children Adjust program, which targets behavioural problems, involves 11 school boards and 60,000 public school children (kindergarten to grade 3) in randomly chosen schools. The activities include a social skills/management program in class, a parent management training program, and an academic support initiative. Preliminary results show that it is useful to allow teachers to modify program components, there was low use of the parent program, most teachers found the other two activities helpful but time-consuming, and support at the school administrative level is crucial. Several publications describing these programs and their rationale are available from the Alliance, for $5-10 each.

For more information:
Ryna Langer
Sparrow Lake Alliance
c/o Department of Psychiatry
Hospital for Sick Children
555 University Avenue
Toronto, ON M5G 1X8
contact@sparrowlake.org (e-mail)
http://www.sparrowlake.org (website)

B27. Suicide Prevention Curriculum

This NWT program involves local community workers completing a 2-week regional training course on suicide prevention and then returning to their community to act as a resource for others. The curriculum was designed by the government of the Northwest Territories in partnership with the Canadian Mental Health Association and the Muttart Foundation of Edmonton. The goals are to obtain training for community caregivers, disseminate information and carry out educational programs for community members. Resources required are community workers willing to take the course and the expenses of the course. An evaluation during the testing period of this program showed that it was well-received in the NWT communities. Trainees agreed they had gained useful knowledge. After 3 years of active use of this program, a further evaluation is being planned for the fall of 1999.

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For more information:
Sandy Little
Community Programs and Services Division
Northwest Territories Department of Health and Social Services
P.O. Box 1320
Yellowknife, NWT X1A 2L9
(867) 873-7926 (telephone)
(867) 873-7706 (fax)
sandy_little@gov.nt.ca (e-mail)

B28. Suicide Prevention Training Programs' Workshop

This is a five-day interactive workshop that has been presented throughout Canada, often as part of a suicide prevention strategy of the RCMP (Aboriginal Policing Branch). The workshop can be adapted to the needs of the particular community and can include inviting Elders to speak about local traditions and conduct ceremonies. The core components include suicide intervention, critical incident stress debriefing, cultural awareness and traditions with Elders (if appropriate), a talking circle, and development of a suicide prevention strategy. Costs of the program vary depending on the location of the community, travel costs for trainers, and local organization costs for room and equipment rental; it generally costs between $3000 and $5000. A detailed community development program for Aboriginal communities, entitled "Saving Lives: Community Development and Suicide Prevention," is a 3-day workshop that aims to help create community initiatives related to suicide prevention. Participants will learn about choosing workable projects, developing teams, initiating action, and evaluating their efforts. We did not find information about evaluations of these two workshops.

For more information:
Suicide Prevention Training Programs (SPTP)
201-1615-10th Avenue SW
Calgary, AB T3C 0J7
(403) 245-3900 (telephone)
(403) 245-0299 (fax)
siec@siec.ca (e-mail)
http://www.siec.ca (website)

B29. Teen Esteem

This program, based in Sarnia, Ontario, is modelled after a successful Hamilton program and involves a series of 40-minute workshops delivered in school during lunch hour. Since 1995, this program has been offered twice a year for 6 weeks in an urban setting. The workshops, limited to 20 girls per session (11-14 years old), are interactive and address a wide variety of topics. Themes include women supporting women, conflict resolution, building friendships, spotting abuse relationships, and introduction to careers. The goals are to provide positive role models for young women, address self-confidence problems, promote career aspirations and higher education, and discourage self-destructive behaviour. A number of female role models are asked to participate in the sessions, including high school volunteers at the beginning of the program. Although staying in school is encouraged, going to university is not necessarily promoted. Girls are recruited to participate on a volunteer basis, with parental permission. Resources required are training for a female volunteer to lead the workshops. The program materials are not available for dissemination. An evaluation based on comments from students and teachers was very positive. Oral feedback sessions a week after the end of the program have recently been implemented.

For more information:
Carol Chamberlain, Administrator *or*
Marilyn Egan, Tean Esteem Coordinator
Big Sisters
Sarnia/Lambton, ON
(519) 336-0940 (telephone)
(519) 336-4932 (fax)

Description of Manuals, Pamphlets, and Other Resource Materials

Manuals

Northern Lifelines: Suicide Information & Resource Manual

This is a manual, produced in 1992, that covers prevention, intervention and postvention for caregivers and community workers. It can be purchased for $60 (plus $10 shipping and handling).

For more information:
Algoma Child & Youth Service, Sault Ste. Marie
(705) 945-5050 (telephone)
(705) 942-9273 (fax)

Walking in Balance: A First Nations Suicide Resource Manual

This is a manual, produced in 1993, that is designed to assist those in a helping role. It can be purchased for $25 (including shipping).

For more information:
Union of Ontario Indians, Toronto
(416) 693-1620 (telephone/fax)

Pamphlets

How to Listen, Understand and Answer a Cry for Help

This is an information pamphlet on suicide warning signs and what to do for a suicidal person. Written in both Cree and English, it was produced by the Northwest Regional Interagency Suicide Prevention Program, Grande Prairie, Alberta in 1991.

For more information:
Suicide Prevention Program
(403) 539-6680 (telephone)

You've Got a Friend: Suicide Prevention & Intervention

This is a pamphlet, produced in 1992, that contains poetry, art and personal stories from members of a support group. It can be purchased for $7 (including shipping).

For more information:
Kwagiulth Urban Society
#4-3023 Carroll Street
Victoria, BC V9A 1R1

Other Resource Materials

Youth Suicide Awareness Presentation Package

This is an 80-page instructional guide with a set of 32 overhead transparencies, designed for use by trainers and caregivers. Its goal is to examine the suicide issue in a 2-hour to half-day workshop with adult groups, but it can also be adapted for an adolescent audience. The package can be purchased for $150 (plus $8 shipping and handling).

For more information:
Suicide Prevention Training Programs (SPTP)
201-1615-10th Avenue SW
Calgary, AB T3C 0J7
(403) 245-3900 (telephone)
(403) 245-0299 (fax)
siec@siec.ca (e-mail)
http://www.siec.ca (website)

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Appendix C1: Resources Used to Review Programs

Alaska Division of Alcoholism and Drug Abuse, no date. Individual, Community and Agency Responsibility for the Prevention of Suicide. Handbook prepared by the Department of Health and Social Services, State of Alaska. Juneau (Alaska).

Alaska Division of Alcoholism and Drug Abuse, 1998. Community-Based Suicide Prevention (Volume 5 Issue 4). Newsletter by the Department of Health and Social Services, State of Alaska. Juneau (Alaska).

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Canadian Mental Health Association, 1998. Mental Health Promotion in Practice: A Documentation of Mental Health Promotion Practices from the Canadian Mental Health Association Divisions and Branches/Regions across Canada. Ottawa (Ontario).

Canadian Public Health Association, 1998. Mental Health Promotion Resource Directory. Ottawa (Ontario).

CDC, 1998. Suicide prevention evaluation in a Western Athabaskan American Indian tribe—New Mexico, 1988-1997. Morbidity and Mortality Weekly Reports 47(13): 257-261.

Centre de prévention du suicide de la haute-yamaska inc., 1994. La prévention du suicide auprès des jeunes en milieu scolaire. Program framework document. Granby (Québec).

Coordinators' Handbook, 1996. Community-Based Suicide Prevention Program.

CRISE, no date. Des Outils Pour la Vie: Répertoire du Materiels de Prévention de Suicide chez les Jeunes.

Fondation JEVI, 1991. Guide de gestion d'un programme d'entraide par les pairs. Handbook. Sherbrooke (Québec).

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Health Canada, 1993. The 1993-94 Resource Listing of Parenting Programs used by the First Nations and the Inuit. Ottawa (Ontario): Mental Health Advisory Services, Medical Services Branch.

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World Health Organization, 1993. Guidelines: The Development and Implementation of Life Skills Programs. Geneva and New York: Division of Mental Health, Health Promotion Unit. WHO/MNH/PSF/93.7A Rev. 1

World Health Organization, 1993. Training Workshops for the Development and Implementation of Life Skills Programmes. Geneva and New York: Division of Mental Health, Health Promotion Unit. WHO/MNH/PSF/ 93.7B Rev. 1

World Health Organization, 1994. The Development and Dissemination of Life Skills Education: An Overview. Geneva and New York: Division of Mental Health, Health Promotion Unit. MNH/PSF/94.7

Appendix C2: Recommended Evaluation Guides

Humanité Services Planning, 1993. How about...Evaluation: A Handbook about Project Self-Evaluation for First Nations and Inuit Communities. Prepared by Jacqueline D. Holt. Sponsored by Mental Health Advisory Services, Medical Services Branch, Ottawa (Ontario).

Health and Welfare Canada, 1991. A Handbook for Indian Communities on Evaluating Health Programs. Ottawa (Ontario): Supply and Services Canada.

Appendix C3: Recommended Guidelines for Ethical Research

Dene Tracking, 1993. A Participatory Research Process for Dene/Metis Communities: Exploring Community-Based Research Concerns for Aboriginal Northerners. Prepared by B. Masuzumi, and S. Quirk.

Inuit Circumpolar Conference, no date. Principles and Elements on Northern Scientific Research.

Inuit Tapirisat of Canada (Research Department), 1993. Negotiating Research Relationships in the North. Background paper for the Workshop on Guidelines for Responsible Research, Yellowknife (NWT), 22-23 September, 1993.

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